Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28501 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O'Haver August 22 ay 2011 Year Juanita Susan 1:45 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Moran Manor Nursing Center Westernport Allegany cial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days oct. 18 215-56-8699 1 M 2 🔀 F 88 Hours Min Maryland 1922 Director Usual Residence of Decedent 28a-f shov 10a. State nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Martel Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral Keyser ¹XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 262 South Main St 26726 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) unknown College (1-4 or 5+) Housework Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Larry Mayhew Helen Teets 19a. Informant's Name/Relationship (Type, Print)
Robert Miller/ son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21 West Harrison St, Piedmont, West Virginia 26750 20a. Method of Disposition 20b. Place of Disposition (Name of 08/26/2011 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1XXBurial 2 Cremation 3 Removal from State Turner Cemetery or other place) Swanton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Seprice Licensee 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failufe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Pryvician** O Brown Der disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 7 10 ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Records, P.O. Box 68760 Division of Vital

> State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jesus Tan, 4 Broadway, Frostburg, MD

AUG 2 3 2011

Registra s Signature

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28502 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August 2011 9:15p M Simon M. Osnos Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery 7301 Brickyard Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday 8. Date of Birth **Funeral** Country) Michigan 1 X M 2 D F Months 579-60-5782 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Maryland Director notified Potomac 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a o Examiner must be Funeral 20854 7301 Brickyard Road permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 🕅 Married ģ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Caucasian 3 🗆 Widowed 4 🗆 Divorced "natural", Completed Year or Dates er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Law Attorney is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 127 is marker Ronald Osnos Berna Mayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7301 Brickyard Road, Potomac, Maryland 20854 Marsha Osnos - Spouse item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of I Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State Brentwood. Maryland 4 Donation 5 Other (Specify) Lincoln Crematory 08/23/2011 21. Sign vire f Funeral Senfice Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician Progressive Glioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and the Hospital or Attending Physician: The law tequires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Other (specify) Pregnant at time of death 9 Unknown g Unknown cat has teen signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner? Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniury X Natural 5 Pending Accident Investigation 24 hours after death Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after d
To the Funeral Direct
Completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) မ

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepa Subramaniam,

AUG 23 2011

M.D.,

MD035067

3800 Reservoir Road, NW, Washington, DC

August 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Porter Physician/ Christinia Ruth М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Western MD Regional Medical Center 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth **Funeral** 04/26/1936 Davs Hours Country) Maryland 75 220-32-4504 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Ridgeley WV Mineral 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 79 Blocker Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Elderly Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Miller ပ Lillian Arbutus Brown Harry Raymond permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 310, Ridgeley, WV 26753 George T. Porter / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Eckhart Cemetery 08/20/2011 Eckhart, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signal re f Funeral Service Licenses 21502 bars 404 Decatur Street, Cumberland, MD 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Coronau Physician/ disease or condition ) Medical resulting in death) Due to (or as a cons duence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying pause given in Part I. 23e. Did tobacco use contribute to the cause of death? seare 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performet!? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 HNo Hospital: မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No injury 1 Natural 5 Pending Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Continuous Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2011 33280 5 000 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) 21502 625 Kent Avenue, Cumberland, MD Sunil K. Gupta, M.D., 31. Date filed (Month, Day, Year, State

Registrar

11-06127 David Larry Pike		-	lelible Ink. Ensure All Cop tment of Health and Mental I ficate of Death	Hygiene Reg. No.								
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) David Larry Pike		2. Date of Death Month Day August 14, 2011  3. Time of Death 0905 hrs								
Funeral		4a. Facility Name (if not institution, give street and number) 1940 Haven Lane  5. Social Security Number 6. Sex 7. Age (In yrs. last	4b. City, Town, or Location of Dea  Dunkirk t birthday)   If Under 1 Year   If Under 24-	Calvert								
Director		226-56-5399 1XM 2F 68 Usual Residence of Decedent		in. 10/19/1942 Foreign Country) MD								
daryland 28a-f show any 1 at once.	ō	MD Calvert	own or Location  Dunkirk	1 X Yes 2 No								
ith the Maryland 23a or 28a-f sho cotified at once.	al Director	10e. Street and Number 1940 Haven Lane	10f. Zip Code 20754	10g. Citizen of What Country? USA								
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f sho injury or other traumantic eveet, the Medical Examiner must be potified at once.	by Funeral	11. Mantal Status  1 Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer  1 Yes 2 No specify:	to Rican, etc.) White, etc.  Specify: White								
)36 thin 72 hours te. than "oatur edical Exam	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  1 2	6a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use in Bookbinder									
1215-0036 d be filed within 7 fental Hygiene. narked other than erveot, the Medica	B	17. Father's Name (First, Middle, Last)  Earl Dewitt Pike  19a. Informant's Name/Relationship (Type, Print)	18.Mother's Nar Anna	ne (First, Middle, Maiden Surname)  Lillian Biser r Rural Route Number, City or Town, State, Zip Code)								
re, MD 21 I and 2 should I Health and Mer	To	Gail Pike/Wife 20a. Method of Disposition 20b. Pla		unkirk MD 20754  Date 20c. Location - City or Town, State								
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Dullar 2 21 Greniation 3 Nemoval Irom State	esapeake Crem. 8/	17/11 Beltsville, MD Raymond-Wood F.H., P.A.								
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease										
Examiner	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Attneroscierottic Cardiovas on the consequence of the c										
e executed cian and rial - transit		d d										
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physiciae: The law requires that the death certificate be executed within 24 hours after death.  To the Fuocral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic preg	nancy 23d. Date of delivery  Month Day Year								
ds, P.O. equires that the een signed by to be detached.	Ď	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available								
al Recor ao: The law r ertificate has b stor, page 2 sh		25. Was case referred to medical	26.Place of Death (Chec	autopsy prior to completion of cause of death?  1  Yes 2 No 1  Yes 2 No No								
Division of Vital Records, To the Hospital or Atteodiog Physiciso: The law require within 24 hours after death. To the Fuocral Director: After this certificate has been si completely filled in by the funeral director, page 2 should b	TO B	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 21	R/Outpatient 3 DOA Other Nurs  8b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	sing Home 5 Residence 6 Other: Scene  28d. Describe how injury occurred								
Divisi ospital or Att hours after de tocral Direct y filled in by 1	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Could to Physician To the heat of The Kernick Could not be determined (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Ho within 24 To the Fo completely	Medical	Check only one)  2 Medical Examiner: On the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and/and manner stated.										
14.2 45		30. Name and address of person who completed cause of death (Item 23	F	August 15, 2011								
CRW ID St Regist		31 Date filed (Month, Day Year) 32 Renistrar's Signature	900 W. Baltimore Street, Baltim	ore, MD 21223								
Regisi		AUG 1771111 Clever B	. /4000-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mary Frances Pyles Physician/ 08/04/2011 Month 07:54 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Center Clinton Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 02/25/1942 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 DX Hours Min. 69 **Director** 577-56-1583 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director MDCalvert Prince Frederick 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Clay Hammond Road 20678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Accountant Paper Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton Thomas Trott, II Mary Wilhelmina Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Pyles/Son 2504 Ann Arbor Lane, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery cremators or other place)
Paul's Episcopal
nurch Cem Annex 1 A Burial 2 Cremation 3 Removal from State 08/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Prince Frederick, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Signal e of Fun I Service Licens Lisa M. Mounts 8200 Jennifer Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ VP Macco Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for as a consequence of: Exami g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Artific Jew who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28506 - State Registrar Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 1700 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Tate Hospice House Linthicum Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Days Min Dec. 2, Year) 949 Hours Director 218-54-5731 61 Wash, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If the 72 is marked other than "---' any injury or other than "---' 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1604 W. Bancroft Lane 21114 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Navy IT Info Technolog Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William F. Perry, Sr. Olive R. Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie P. Warren / Sister 1445 Jordan Ave., 21114 Crofton, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date  $\square$  Burial 2  $\raisebox{.5ex}{$\not$$}$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place, 8/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD . Signature of Fune Ser 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy Bowie, MD 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only or learning the shock of the s cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ SOPHAGUS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Gause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of HOUSE 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific

State

Registrar
DHMH 17 Rev 7/2009

ause of death (Item 23a) (Type, Print)

17 2011

			For State	State of Ma	ırylanı		artment of I <i>tificate of L</i>		Mental H		2011	2850
			Registrar     Decedent's Name (First, Middle)	e, Last)		061	incate or i	Jean	2. Date of D			3. Time of Death
	Physicia Medi		Mildred Schwart						August	1	2011	9:45 A
	Examir	ner	4a. Facility Name (if not institution					r Location of Dea	th		c. County of Dea	
	Funeral	Г	12916 Good H11.  5. Social Security Number	6. Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Year	Spring If Under 24 Hrs		irth	lontgome:	rthplace (State or Foreig
	Director		056-10-5260	1 □ M 2 🕱 F	9	3 Yrs.	Months Days	Hours Min	March	17.	1918 Ne	W York, NY
	and show at	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				-	10d. Inside City Limits
	Maryla 28a-f t atified	<b>Funeral Director</b>	Maryland Montgo	omerv	Si	lver S	bring					1 □ Yes 2 👿 N
	h the	a Di	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What C	ountry?
	orth with mit mas 2% must	nuer	12916 Good H111	L Road 12. Was Decedent Ev		140.1	2090 Vas Decedent of H		Specify Von au Na		Inited St	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 Never Married 2 Mar 3 X Widowed 4 Divorced	Armed Forces?  1  Yes 2 N	lo	l li	Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	,-	14. Race - Am Black, Whi Specify: <b>Wh1</b>	te, etc.
15-0	"2 hou "natu edical	plet		nt's Education est grade completed)	I	(Give I	lent's Usual Occup	during most of wo	orking	16b.	Kind of Business	Industry
121	ithin 7 iene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+	-)	Secre	O NOT use retired)			Gov	ernment	Agency
	filed wall Hyg I othe vent,	Be	17. Father's Name (First, Middle,	Last)		DCCIC	·cury	18. Mother's Na	ame (First, Middle			1.601.07
ylaı	ild be Mente larkec atic e	<u>ا</u>	Emmanuel Schwar	rtz				Fannie	Smith			
Maryland	shou h and 7 is m traum		19a. Informant's Name/Relations			l	g Address (Street					
	and and Healt tem 2		Marcy Pollan, 20a. Method of Disposition	Daughter	20b. Pla		Good Hi	II Road,	Silver Date		ing, MD Location - City o	
moi	Page 1 nent of nt: If i		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (	3 ☐ Removal from State	ce	metery, cren	natory or other place rk Crema			1	ŕ	Maryland
Baltimore,	permit. F Departm Importa any inju		21. Signature of Funeral Service		LEOG	22	. Name and Addre	ss of Facility	Simple T	ribu	ite	yland 20852
(	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused to only one cause on each line.  Myocard		. Do not ente	r the mode of dyin				•	Approximate Interval Between Onset and Death immediate
-	Medical Examiner	ı	resulting in death)	Due to (or as a								
		Jer	Sequentially list conditions of the sequence o									
	cate be executed physician and sthe burial transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.									
	e exec	a E	resulting in death) Last	Due to (or as a								
092	ate be	edical		d								
Box 687	eath certifica attending p for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal	death 3	Ectopic pregnand Other (specify)	су			23d. Date of de Month	elivery Day Year
). B	t the der by the s tached	hysi	1  Yes 2 No 9 Unknown	9 🗆 Unknown			(-)					
P.O.	ires that signed k d be det	þ	Part II. Other significant condition		id tobacco use contribute to the cause of death?							
rds,	require been si should b	eted							1	Yes :	2 <b>X</b> No 3 □ F	Probably 4 🗆 Unknow
of Vital Records,	Attending Physician: The law requires that the death certificate be executed redeath certificate be executed act death.  **redeath**  *	Completed							24a. Wa: auti per 1 🗆 Yes	opsy	prior to	utopsy findings available completion of cause of s
/ita	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:		D/Outrotion	Oth	ace of Death (Cheer:			о П он <i>1</i> 0	
of/	ding Phy :h. After this funeral c		1 Impatient 2 Etyoutpatient 3 DOA 4 Nursing Home 5 & Residence 6 Dotner Spe									спу)
ion	ttendin death. tor: Aff the fur	ifica	1 X Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation	injury	M 1 🗆	Yes 2 No					
Division	Il or Attend after death Director: /	Certificate:										ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completed filled in E	Medical	(Check 2 L Medical E	Physician: To the best of m examiner: On the basis of exa Nurse Practioner: To the be	mination	and/or invest	igation, in my opinic	on, death occurred	at the time, date	and plac	ce, and due to the	cause(s) and manner stat
	vithi routh		29b. Signature and title of certifier				29c. License				ate signed (Mon	
	4		PVK	$\sim$	>		D00	35045		Aug	gust 16,	2011
			30. Name and address of person	1				0 01	1.		00000	
	Stat	te -	Philip G. Hen  31. Date filed (Month, Day, Year)				rive #20	u, Olney	, Maryl	and	20832	
	Registra		AUG 18 20	111 Senda	A.	par						

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month. Day Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 121 OLD ELM ROAD CECII NORTH EAST Social Security Number **Funeral** 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday, 8. Date of Birth WESTERS LESTER PENNSYLVANIA Hours 211-28-0168 APRIL Day Yell 938 73 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2XXNo MARYLAND CECIL NORTH EAST 10e. Street and Number 10g. Citizen of What Country? Funeral 121 OLD ELM ROAD 21901 UNITED STATES 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ NMARINES

If Yes, Give 1955-57

Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced WHITE of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) AUTOMOBILE Elementary/Seconday (0-12) College (1-4 or 5+) SPRAY PAINTER MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ EARL PEIRSON ADA ELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra VIOLET PEIRSON / SPOUSE NORTH EAST, MARYLAND OLD ELM ROAD, 21901 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
BURN REGULAR
PTIST CEMETERY 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal LANDENBERG, PENNSYLVANIA 4 Donation 5 Other (Specify, 2011 Signature of Piner Service 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. <u> 27 SOUTH MAIN STREET. NORTH EAST.MARYLAND21901</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed should be detached for use as the burial-transi Cause (Disease or linjury been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ရ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of 🛊 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY SHAHNAWAZ KHAN 2533 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28509 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August HOA 201 Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death unty of Death If Under 24 Hrs. 7. Age (In vrs. last birthday) If Unde Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Min Hours 218-12-4641 07/21/1924 Director Yrs 87 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 Bond St. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 \( \subseteq \text{No. 1943} \) Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2X No Specify. 3 X Widowed 4 □ Divorced Completed 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Δ Retail Department Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael Perrin May Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Bubert, stepson 32 Bond Street, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Carroll Cremation 08/16/2011 Hampstead, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Pritts Funeral Home & Chapel 22. Name and Address of Facility 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between t and Dea Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequen of) Examiner Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No be detached for Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? within 24 hours after death.

To the Funeral Director, After this certificate 1 Yes 2 No 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical director, To Be 26. Place of Death (Check only one) 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier WJL ZIVA

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

AUG

gistrar's Signature

7/0

Obrecht

Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Plea										-	re Legib	le.			
		For _ State		Sta	ate of M	larylan	nd / Dep				and I	vienta	l Hygie	ne	1	20510		
		Registrar	e (First Middle	l act)	Certificate of Death							Reg. No 2011 28510						
Physiciar		1. Decedent's Name (First, Middle, Last)  WILLIAM ROY PROCTOR  2. Date of Death  Month AUGUST 18,										Pay 20	ear 11	3. Time of Death 7:30 P M				
Medica Examine													4c. County of		7.30 1			
1		CHARLES CO.			1.		PLATA				CHARL	ES						
Funeral Director		5. Social Security Nu.	347	6. Sex	☐ F 7. Ag	ge (In yrs. I 81	last birthday) Yrs.	Month:	ler 1 Year s Days	If Unde Hours	Min.	8. Date	of Birth th, Day, Ye			place (State or Foreign try) INGTON, D.C		
show d at	5	Usual Residence of 10a. State		10c. City, Town or Location										1	10d. Inside City Limits			
Maryli 28a-f otifiec	irect	MARYLAND	E GEOR	GEORGES CLINTON										1 🔀 Yes 2 🗌 No				
th the	Funeral Director	10e. Street and Number				10f. Zip Code								at Cour	-			
ems 2	nue	8600 MIK	12. Wa	DRIVE 20735  2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi						rigin? (Sp	ecify Yes	NITED S		American Indian,				
s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	হ	1 Never Marri	ned Forces? Yes 2 <b>X</b> es, Give	l No			ecify Cuba			Rican, et	C.)	etc.						
ours a	eted	3 Widowed			ar or Dates.						/· 					CICAN INDIAN		
n 72 h an "na Medic	Completed		cify only high	est grade comp		5.1\	16a. Dece (Give life. D	kind of w	ork done c se retired)	ation during mo	st of work	king		16b. Kind of Business Industry WASHINGTON SUBURBAN				
filed within 72 hours after death with the Maryland al Hygiene. 4 other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at		9TH GRAI			lege (1-4 01 1	J+)	LAI	BOREI	2				S	ANITARY	CO	MMISSION		
d 2 should be filed within 72 hours aith and Mental Hyglene. n 27 is marked other than "natura r traumatic event, the Medical E.	To Be	17. Father's Name (F ROGER PRO		Last)								me (First, Middle, Maiden Surname) TH ERIN PROCTOR PROCTOR						
hould Ind Me s marl umati		19a. Informant's Na		hip (Type, Print	t)		19b. Maili	ng Addre	ss (Street a					ty or Town, Stat				
nd 2 sl ealth a m 27 is ser tra		WANDA M.		R / DAU	IGHTER									ARYLAND		20601		
permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau		20a. Method of Disp 1 ☐ Burial 2X	Cremation	3 Remova	al from State		Place of Dispo cemetery, crea	matory or	other plac			Date		c. Location - Ci				
nit. Pa artmer ortant injury	ŀ	4 Donation 5 Other (Specify)  BRINSFIELD-ECHOLS CREMATORY AUGUST 25, 2011 CHARLOTTE HALL, MARYLAND																
Dep Imp any onc		21. Stricture of Funeral Service Licenses 122. Name and Address of Facility HOME, P.A.  THORNTON FUNERAL HOME, P.A.  3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640																
,		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													Approximate			
Physician/		Immediate Cause (Fi		a	Fe	zilu	ive.	10	+1	Juli	10					Onset and Death		
Medical Examiner		resulting in death)			oue to for as	a consequ	uence of):	120	Lk	20								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):																
e executed sian and urial-transit	xam																	
@ Fig. 6	اڃ	resulting in death) Last Due to (or as a consequence of):																
cate b	edic			d														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent			es, outcome			Ectopic	nreanana	24				23d. Date of	of deliv	ery		
the att	Sici	in the past 12 months?  1 ☐ Ves 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown												Month		Day Year		
ad by detach	M.	Part II. Other signifi	icant conditie	ons contributin	ng to death b	out not res	sulting in the u	underlying	g cause giv	en in Par	t I.	23e. Did tobacco use contribute to the cause of d						
uires ti	od be												2 No 3	No 3 Probably 4 Unknown				
aw req	Completed											24a	. Was an			psy findings available		
The la	500											1 [	autopsy performe Yes 2		th?	2 No		
sician: certifii rector,	Re	25. Was case referre examiner? 1 ☐ Yes 2 ☐		Hospital:	: _				Otho	6. Place of Death (Check only one) Other:								
g Physer this leral di	e: 10	27. Manner of Death	1		. Date of inju	ıry	ER/Outpatie 28b. Time o		28c. Injury	/ at	lursing H	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred						
eath. or: Aft he fur	ticat	1 ⚠ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pendir	gation	(Month, Da	y, rear)	injury	M	work 1 🗌	? Yes 2	□No							
or Att	Certificate:	4 Homicide	6 U Could determ		Place of Injuding, etc	ury - At ho c. <i>(Specify</i>	ome, farm, str	eet, facto	ry, office				ation (Stree or Town, S		r Rurai	l Route Number,		
hours hours neral	edical	29a. Certifier 1	Certifying	Physician: To	o the best of	my know	ledge, death	occured a	at the time,	date and	I place, a	nd due to	the cause(s	s) and manner a	ıs state	ed.		
the Ho nin 24 l the Fu	Med	(Check 2		xaminer: On t	the basis of e	examination	n and/or inves	tigation, i	n my opinio	on, death o	occurred a	it the time.	date and p	lace, and due to use(s) and mann	the ca	use(s) and manner stated		
Neith No.		29b. Signature and t	itle of certifie	^	MT	\		29	9c. License		760	30		. Date signed (A		*		
	-	30. Name and addle	W O	who committee	/ ·   _	Jooth #tage	230/75	Print\	DO	U >	17	17	AU	GUST 19	, 2	.011		
231		MANISHA <sup>U</sup>	J. JAR	IWALA,				,	DRIV	E, #3	103.	WALD	ORF.	MARYLAI	<b>I</b> D	20602		
State Registra		31. Date filed (Month			32. Registra	ar's Signal	turo -	bare		, ,,						-0002		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28511 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 2011 Ī6 Richard Paul Penna 6:45 PM August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Institutes of Health National Bethesda 7. Age (In yrs. last birthday) 75 yrs. 8. Date of Birth Sept 7, 1935 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 🗷 M 2 🗆 F Hours California 553-42-8963 Director Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 XNo Maryland Washington Knoxville 10f. Zip Code 21758 10e. Street and Number 1119 Valley Road 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. Give kind of work done during most of working life. DO NOT use retired)
CEO (Specify only highest grade completed) 5+<sup>College (1-4 or 5+)</sup> Elementary/Seconday (0-12) Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Valentina Garino Paul Penna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 Valley Road, Knoxville, Maryland Elizabeth Penna - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 8-19, 2011 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 21704 1621 Opossumtown Pike, Frederick, Maryland 23. Part 1. Enter the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
14 months Immediate Cause (Final Physician/ Glioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imply that initiated events Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 Yes 2 XNo Yes 2 🗀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 1 ☐ Yes 2 📉 No ٩ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury work? Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 

Baltimore, Maryland 21215-0036

State Registrar

0

(Check

only one 29b. Signature and title

3 🗌

Perr 31. Date filed (Month, Day Ye

marke

MI

Smith

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

148544

10 Center Drive, Bethesda, MD

29d. Date signed (Month, Day, Year)

20892

17,2011

State

10

Registrar

within 2

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Hemen Shah, MD

only one)

31. Date filed (Month

DHMH 17 Rev 7/2009

arks

65 C TJ Drive, Frederick, MD 21702

egistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

8-18-11

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2015 tare of Maryland 9 6942011 Health and Mental Hygiene 28513 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mae 4:40 P M 01a 16, 2011 Reeves August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Asbury-Solomons Health Care Center Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🏋 F Months Days Hours 418-03-9760 95 Director Alabama Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Dowell 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14194 Foxhall Road 20629 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 lith and Mental Hygiene.
7 Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) <u>Federal Trade Coordinator</u> U S Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Ed Sargent Beulah Isabelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trac . Page 1 and 2 s ment of Health JoAnn Patterson - Daughter P. O. Box 91, Dowell, Maryland 20629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 09/28/2011 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Arlington National Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Or set and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ COMPLICATIONS FM FNTIA Medical Examiner 4 FARC FMURRHAUE SUBARACH NOI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examil use as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Day Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? δ DISORDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 ☐ No 1 Ves 2 No the Hospital or Attending Physician; hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 1 No Other: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital or within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d, Date signed (Month, Day, Year) August 17, 2011 1/2g

State

Baltimore, Maryland 2121

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year)

AUG 19 2011

Aug 1 5 fames

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

John H. Weigel, MD 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death August 12, 2011 Physician/ 7:00 A M Delay Vivan Riggleman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Hillside Drive Huntingtown Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours 1 ▼ M 2 □ F West Virginia 1070571925 Director 233-42-4173 85 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral U.S.A. Hillside Drive 20639 2546 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or i 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 self employed technician home improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lessie Dean Riggleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 2546 Hillside Drive, Huntingtown, MD Benita Riggleman, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lahmansville, WV Lahmansville Cemetery 08/16/2011 Signature of Funeral Service Liden 22. Name and Address of Facility 26847 Basagic Funeral Home, P.O. Box 400, Petersburg, WV Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fails re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HART disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SCHENIC CARDIDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last APTERT CORGNARY and -trans Due to (or as a consequence of) nding physician use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year ed by the a detached 1 g Unknown P.0. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate Yes 2 No 2 🗌 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Thesidence 6 Other (Specify) 4 hours after death.

uneral Director: After this ed filled in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🔲 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted (Check Gertifying Nurse Practioner: To the best of my knowledg 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26358 August 12, 2011

fRW

State

Registrar

John

31. Date filed (Month, Day,

110 Hospital Rd.,

anna

Registr s Signature

Suite 310, Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Weigel, M.D.

Amend #19a pe AACO Health I		Q 2/ 11 VALI							
	•	For State of Maryland / De	epartment of Sertificate of		Mental Hy	2011	28515		
		1. Decedent's Name (First, Middle, Last)	Dealli	Reg. No.  2. Date of Death 3. Time of De					
Physici Med		DOROTHY L. ROSS			Month	Day Year	21416 M		
Exami	ner	4a. Facility Name (if not institution, give street and number)  Anne Arundel Medical Center		or Location of Deat	h	4c. County of Death	ndo1		
Funera	Т	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year				ce (State or Foreign		
Directo		246-44-8775	. Months Days	Hours Min.	Feb. 2	2 1932 N. C	arolina		
/land f show	tot	10a. State 10b. County 10c. City, Town or				10d	d. Inside City Limits		
e Man r 28a- notifie	Director	Maryland Anne Arundel Annapo					1 Tes 2 X No		
<b>laryland 21215-0036</b> should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral	1008 Monroe St.	10f. Zip Code 2 1	403		10g. Citizen of What Country USA	1?		
death r items		11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of I		pecify Yes or No	14. Race - American			
036 s after raf", or	d by	1 ☐ Never Married 2 ☐ Married  3 X Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1 ☐ Yes 2X N		0 ( 110011, 010.)	Black, White, etc			
5-0 2 hour	Completed	15. Decedent's Education 16a. De	cedent's Usual Occu		deina	16b. Kind of Business Indus	stry		
21215-0036 within 72 hours after giene. er than "natural", o, the Medical Exami, the Medical Exami	Solution	Elementary/Seconday (0-12) College (1-4 or 5+)	Entrepre	)	Kilig	Convenient	Storo		
laryland 2121 should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last)	, Maiden Surname)	2016					
Dre, Maryland 1 and 2 should be filed of Health and Mental Hy filem 27 is marked oth		Albert Cole	Moses	ses					
≥ 5 ₹ 5 ₹			-			er, City or Town, State, Zip Coo ${\sf s}$ , ${\sf Md}$ . ${\sf 21403}$	ie)		
Baltimore, permit. Page 1 and Department of Hee mportant: If item mny injury or othe nnce.		20a. Method of Disposition 20b. Place of Di	sposition (Name of erematory or other pla		Date	20c. Location - City or Town	n, State		
Baltimor permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Specify)	d Cemeter	ry 8–2	20-11	Goldsboro,	N.C.		
Balti permit. Departr Importr any inji		21. Signature of Funeral Service Licensee				cuary, P.A. oolis, Md. 2	1401		
	Γ	23a. Part 1. Ent. The disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.				rrest, A	pproximate		
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	where	e oou	lie a	"	Inset and Death		
Examiner		Due to (or as a consequence of):	0				lears.		
p its	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying					1424 3 1		
executed an and ial-transi	Exar	Cause (Disease or linjury that initiated events resulting in death) Last   C. Due to (or as a consequence of):	<del></del>						
ox 68760 ath certificate be executed attending physician and for use as the burial-transit	dical	d							
68760 sertificate b oding physic	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							
Box death c he atten	iciar	in the past 12 months?  1 ☐ Yes 2 🕶 No 4 ☐ Pregnant at time of death	B	су		23d. Date of delivery Month Da			
P.O. E that the coned by the edetache	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the							
ords, P.O. Box 68 v requires that the death cert been signed by the attendir should be detached for use	Completed by	Take Substitution and Contributing to death but not resulting in the	e underlying cause g	iven in Part I.		tobacco use contribute to the o			
w request speer	plete				24a. Was	an 24b. Were autopsy	/ findings available		
Rec The la	Com				auto perf	opsy prior to compormed? death?  2 ☑ No 1 ☐ Yes 2	oletion of cause of  ☐ No		
/ital	Be	25. Was case referred to medical examiner?  1 24 Yes 2 □ No Hospital:		lace of Death (Che					
of V ng Phy ter this	te: To	27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injur	4 □ Nursing F ry at		dence 6 Other (Specify) how injury occurred			
tendir death. tor: Af the fur	Certificate:	2 Accident Investigation	M 1 🗆	k? ]Yes 2 ☐ No					
Division of Vital Records, all or Attending Physician: The law requires is after cleath. It Director: After this certificate has been signed in by the funeral director, page 2 should be an in the funeral director.		4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location ( City or To		t and Number or Rural Route Number, tate)			
Hospit 4 hour Funera	Medical	29a. Certifier (Check (Check Check Check (Check Check Check (Check Check Check (Check (Check Check (Check	h occured at the time	e, date and place, a	nd due to the ca	ause(s) and manner as stated.	/a) and manner atotad		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	e, death occurred at the	ne time, date and pla	ice, and due to the	ne cause(s) and manner as state	d.		
€ 5p		Medden		IH33(	.	29d. Date signed (Month, Day	, rear		
2		30. Name and address of person who completed cause of death (Item 23a) (Type K.S. Courses Aduce		3 3			-		
Sta	te	31. Date filed (Month, Day, Year) 7 2011 32. Redistrar's Signature	ETZ						
Registr	ar	AUG I (2011) Senera B.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28516 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8/13/2011 9:30 A M John Bernard Reilly Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 7201 Masters Drive Potomac Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 ★ M 2 □ F Months (Month, Day, Year) 21 **Director** 227-12-6407 90 Yrs. VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Montgomery Potomac 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7201 Masters Drive 20854 S A 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Date 1.942 – 1946 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International 16b, Kind of Business Industry (Specify only highest grade completed) filed within 72 ial Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Executive 4 Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 1 and 2 should be fill of Health and Mental filem 27 is marked ( ၉ Charles Francis Reilly Mary Miney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Northfield RD Bethesda, MD 20817 Sean B. Reilly or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 4 Donation 5 Other (Specify) National Crematory 8/19/11 Falls Church, VA 21. Signature of Juneral Service Lic 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 mons. Immediate Cause (Final Pnysician/ disease or condition Non - Hodgkin's Lymphoma Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to innectiate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-tr-nsit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performed' Yes 2 death? 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending Investigation within 24 hours after death.

To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Prectioner: in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 19 2011

Dr Fred Smith 5454 Wisconsin Ave Chevy Chase, MD

D003 3293

8/15/2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_1	For State Registrar		State of r	viaryian		rtment of tificate of		and iv	пептат пу	Reg. N	60		285	17	
	Physicia		1. Decedent's Name (First, Mid Emajean Davis Ro						2. Date of De Month <b>August</b>	Day Year							
	Medic Examin		4a. Facility Name (if not instituti						c. County	c. County of Death							
1	Funeral		11409 Maryvale R 5. Social Security Number	st birthday)	Upper Mar1boro If Under 1 Year If Under 24 Hrs. 8. Date of Birth					Prince Georges  9. Birthplace (State or Foreign							
	Director		338-30-0850 Usual Residence of Decedent	1 🗆	м 2 <b>ХХ</b> F	93	Yrs.	Months Days	Hours	Min.	June 16,	<sup>y,</sup> 191	8	Coun	<sup>try)</sup> Ohio		
	fand f show d at	tor	140 Co. d.												10d. Inside City L	- 1	
	e Mary r 28a-1 notifie	Direc	Maryland Prince 10e, Street and Number	ce Geor	rges	Uppe	er Marlb	DOTO 10f. Zip Code					1 ☐ Yes 2√√ No 10g, Citizen of What Country?				
	with th	Funeral Director	11409 Maryvale Rd					20772				USA		Wilat Cou	nt y :		
	death r items iner m		11. Marital Status	- 1	2. Was Deceder Armed Force	5?	3. V	Vas Decedent of Yes, specify Cub	Hispanic Or oan, Mexica	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)			e - Americ ck, White,	can Indian, etc.		
	rs after rral", o Exam	ed by	1 Never Married 2 No	X No	1	☐ Yes 2XXN	o Specify	<i>'</i> :		Specify: White							
5	and 2 should be filed within 72 hours after death with the Maryland Health and Mentall Hygiene. Health and Mentall Hygiene. The firem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	Completed	15. Dece (Specify only hig	(Give k	lent's Usual Occu kind of work done O NOT use retired	during mos	st of worki	ing	16b.	Kind of B	usiness In	dustry					
7 7	within giene. ner tha t, the N													Educa	tion		
2	be filed ental Hy ked oth c even	To Be	17. Father's Name (First, Middle Irwin Davis	e, Last)						ner's Nam n L. S	e (First, Middle. Savre	Maider	n Surnam	e)			
d y	should and Me is mar aumati	10	19a. Informant's Name/Relation	nship <i>(Type</i>	, Print)		19b. Mailin	g Address (Stree	-			er, City o	or Town, S	State, Zip	Code)		
ž Ľ	1 and 2 should be of Health and Men item 27 is marke other traumatic		Patricia Rowland 20a. Method of Disposition	(Daug	hter)	20h P		Maryvale 1	Rd. Upp		rlboro, N			- City or T	own, State		
=	- =		1XX Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3 🗆 R	emoval from Sta	ate c	emetery, crem	vational C			24 <b>, 2</b> 01	1					
Daltillion	permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licenses MO1555  22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 2											c.			
		Н	23a. Part 1. Enter the disease	or complic	cations that cau	sed the deat							Jil, I'II	2073	Approximate		
F	hysician/		23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Onset and Death														
J	Medical Examiner		resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):														
	p #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events														
	cate be executed physician and s the burial-transit	edical Examiner	Cause (usease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):														
8	ate be e ohysicia the bur	dical	d														
00			IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of Date									ate of deli	very				
000	e death the atte hed for	Physician/M	in the past 12 months?  1  Yes 2 No 9 Unknown 9 Unknown Month									onth	Day Yea	ar			
	that the ned by e detac	by Ph															
ecords,	equires een sig nould b													obably 4 Un			
000	e has b ge 2 sh	Completed	24a. Was an 24b. Were autopsy prior to the second s											prior to codeath?	ompletion of cau	ise of	
VITAI IN	cian: Ti ertifical ector, p	Be C	25. Was case referred to medie examiner?	1	ospital:				Place of De	ath (Chec	l 1 ∐ Yes	2 (-)	NOT	100			
OT VI	physier this ceral dire	e: To	1 Yes 2 No 27. Manner of Death	The state of the s	1 Inp	injury	ER/Outpatier 28b. Time of	28c. Inj	ury at	Nursing H	ome 5 Res 28d. Describe				<u>5</u> y)		
000	tending leath. :or; Afte the fun	Certificate:		nding estigation uld not be		Day, Year)	injury	M 1	ork? Yes 2	□No							
UNISION	al or Att s after d I Direct d in by			ermined		Injury - At ho etc. (Specify		eet, factory, office	9			n (Street and Number or Rural Route Number, Town, State)				;	
_	To the Hospital or Attending Physician: The law requires that the death certification 24 hours affect death.  To the Funeral Director, After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medic	al Examine	er: On the basis	of examinatio	n and/or inves	occured at the tin	nion, death	occurred a	at the time, date	and pla	ce, and di	ue to the c	ause(s) and mann	ner stated.	
	To the To the compl	Σ	only one) 3 ☐ Certify 29b. Signature and title of cert	-	Practioner: 10	the pest of th	y knowledge, (	29c. Licer	nse number		ce, and dde to t		d. Date signed (Month, Day, Year)				
			30. Name and address of pers	DO WITO CO	noleted cause	of death (Item	n 23a) (Type F		30617	24			5	1/8/1			
	BB5		Mark Siviere	100C		olumbi	$\cap$ 1	Suite Pl-	10	(dlam	Gd MD	20	046				
	Sta Registra		31. Date filed (Month, Day, Yea	2621	32. Reg	istrar's Signa	iture	barker									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06154 State of Maryland / Department of Health and Mental Hygiene Phillip Joseph Snoy 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day August 15, 2011 0715 hrs Medical Examiner PHILIP JOSEPH SNOY 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery 14901 Montevideo Road Poolesville 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) Months Days Hours 09/03/1951 Director IN 335-46-3497 1 Y M 59 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 V No s 23a or 28a-f show e notified at once. POOLESVILLE MONTGOMERY Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20837 USA 14901 MONTEVIDEO ROAD 14, Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 V Married Yes WHITE 1 Yes 2 V No specify: 4 Divorced If Yes, Give Year Specify: 3 Widowed ≦ r Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. GOVERNMENT 21215-0036 VETERINARY PATHOLOGIST 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BETTY C. CARR B JOSEPH B. SNOY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0.837 19a. Informant's Name/Relationship (Type, Print ) 14901 MONTEVIDEO RD., POOLESVILLE, FRANCIE DOUGHERTY/SPOUSE 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 08/17/2011 FREDERICK, MD STAUFFER CREMATORY 4 Donation 5 Other Specify. 22. Name and Address of Facility Foneral Service Licensee 21. Signature of P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 26a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Carbon Monoxide Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial - transi sician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o <u>ā</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown ے Completed Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? Yes 2 ✔ No death? 1 Yes 2 No certificate 25. Was case referred to medical 26.Place of Death (Check only one) of Vital å Dther Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) Aug 15, 2011 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Subject inhaled exhaust fumes Certification Natural 0630 hrs 1 Yes 2 ✔ No Division 5 Pending death. Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide hours after 6 Could not be or Town, State) 14901 Montevideo Road, Poolesville, MD e Funeral I (Specify) garage Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated

29b. Signature and title of certifier

(hue)

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature arked

29c. License number 29d. Date signed (Month, Day, Year)

August 16, 2011 O.C.M.E.

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 20<sup>Year</sup> 2330 Α. Sullivan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours (Month Day Year) 10/7/1936 Washington, DC Director <u>578-46-332</u>6 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 I No DC Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i Funeral within 72 hours after death with 20011 USA 401 Madison St. N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

Y Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha College (1-4 or 5+) 12th Government <u>Mail Handler</u> permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sullivan Virginia Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20011 Claudia Sullivan/ Wife 401 Madison St. N.E. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Lincoln Memorial ukn Suitland, MD Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Urosepsis

Due to (or as a consequence of) Medical resulting in death) Examiner Alzheimers Dementia Sequentially list conditions, if any, leading to immediate cause. Enter of cause (Disease or iinjury Examine Unstageable Aseral Pressure Ulcers Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the be detached ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type 2 Diabetes Mellitus 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi

State

DHMH 17 Rev 7/2009

Registrar

only one)

31. Date filed (Month,

29b. Signature and title of certifier

AUG 1 9 2011

Barbara Supanich,

Superich REM UD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RSM MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 0065485

Silver Spring, MD 20910

29c. License number

1500 Forest Glen Rd.

2 Medical Examiner: On the basis or examination almost investigation, almy specifically determined at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28520 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Ramona G. Smith August 8:20 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Howard Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) **Funeral** 09<u>/09/1928</u> Country) Pennsylvania 1 🗆 M 2 🗶 F Months Days Hours Yrs Director 210-20-9629 82 Usual Residence of Deceden 28a-f show at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director items 23a or 28a-f s per must be notified 1 Tes 2 No MD Howard Columbia 10e. Street and Number 10g. Citizen of What Country? Funeral 11001 Swansfiled Road United States 21044 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7.2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 4 Anesthesiologist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Green Modestein Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Royce Smith, Sr./son 11001 Swansfield Road Columbia, Maryland 21044 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mulial 2 ☐ Cremation 3 ☐ Removal from State injury or Crest Lawn Mem. Gardens 8/22/2011 | Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family, F.H. 21. Signature of Funeral Service Lice 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Complications disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): -transit Exam To the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical Box 68760 as the k IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HUSPICE After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1. Natural injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3. Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Black

egistrar's Signatur

eneura

AUGUST 17, 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Month** Physician/ C Doris K. Shanley Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western Maryland Medical Center Cumberland 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth **Funeral** 1 🗆 M 2 🗙 F Days Hours Min Months 98 040-03-6270 Director July 20, 1913 Connecticut Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Maryland 1 X Yes 2 No Allegany Frostburg 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Number 233 Armstrong Avenue or items 23a Funeral U.S.A. 21532-13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status other traumatic event, the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) t of Health and Mental I If item 27 is marked o ల Dennis Keelev Katherine Fitzgerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) **Brian Shanley** 21532-Maryland son 231 Armstrong Street Frostburg 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ō Department of Important: If any injury or Cumberland Maryland Maryland Veteran's Cemetery August 12, 2011 . Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. ician/ acute Gastrointestinal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner acute rena Sequentially list conditions Examine frank, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events -transit To the Hospital or Attending Physician; The law requires that the death certificate be executed neumonia and Due to (or as a consequence of) resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached the 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) nin 24 hours after death.

the Funeral Director: After this certific

npleted filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 XInpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The continue of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nie Marris, Name and address of person who completed cause of death (Item 23a) (Type, Print) WillowBROOK Rd. Cumberland. MD 21502 12500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 33,5 M Mary Frances Sarver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegany <u>Cumberland</u> 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. 1 🗆 M 2 💢 F Months (Month, Day, Year) 03/28/1951 Director 219-56-9708 60 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland the Medical Examiner must be notified at Director Allegany Cresaptown 1 🗌 Yes 2 🕅 No 10e, Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 12812 Darrows Lane Funeral 21502 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō ģ 1  $\square$  Never Married 2  $\square$  Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify. "natural" 3 - Widowed 4 \ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Registered Nurse permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Werner, Sr. Frances Elizabeth Theorig Kenneth Clarence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15673 S. Young Rd, Lot 14, Greencastle, PA 17225 David Sarver / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State Cumberland Crematory 08/25/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. tu of Funeral SerMice 404 Decatur Street, Cumberland, MD Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition tun Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 Live Felan in the past 12 months?
1 Yes 2 No Month Year Day cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this of in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined after City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier vit 23,2011 lin 5

Registrar

arke

924 Seton Drive, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Vik Poonai, M.D.,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris Ann Sydnor 3:00 08/08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 4665 Huntingtown Road Huntingtown Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 屎 F Months Days Hours Min. **Director** 579-20-1997 86 Yrs. DC 02/15/1925 Usual Residence of Decedent 10a, State 10b. County death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Huntingtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 Neptune Lane 20639 U.S.A. permit. Page 1 and 2 should be filled within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2XXNo 1 ☐ Yes 2XXNo Specify. Specify: White 3 Wildowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C&P Telephone Company Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Irving Higgs Ida C. Copp 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susann Dishner Sydnor/ in-law 4665 Huntingtown Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 08/11/2011 | Suitland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ HYPER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DISENSE STAGE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform Yes 2 death? 2 🗌 No of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 5 Residence Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending **N**atural Division 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 20059055 M CIARAN BROWNE, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 WEST DAMES BEACH LO FREDORICK mo 20678

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

**AUG 0 9** 

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28524 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 08 Physician/ a Year Swee hr 1807 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Maryland Medical Center Baltmure If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 AM 2 □ F Days Min 1985 New York 25 070-70-0645 Yrs. Director Aug. Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bath If Item 23a or 28a-f sho tant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho iury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Prince George's Bowie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 6102 Gothis Lane 20720 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates. 2004-11 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Coast Guard 12 PO3 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Holly A. Tyson Michael B. Sweeting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6102 Gothic Lane, Bowie, MD 20720 Holly A. Tyson / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or cemetery, crematory or other place ■ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 8/22/2011 Crownsville, MD 4 Donation 5 Other (Specify) Beall Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 230 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician open Delvic REPUTICATION APPRICATION MEDICAL EXAMINES disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a nonsequence of): burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the l IE EEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Year Month Day Yes 2 No signed by the a 1 ☐ Yes 2 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 옏 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1359 ☐ Natural 5 Pending Motorcycle into felephone 2 Accident 12/2011 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ROUTE 5, LEXINGION PARK, M. determined Lexington Park, mD Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 08/15/2011 Howell BMD 19739

This.

Registrar

Floyd

Baltmere, MD 21201

22 South Greene St.

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOWITT, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 14. Elinor D. Stanford 2:30a M 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing Home Montgomery Sandy Spring Social Security Number . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Month, Day, Ye. Massachusetts 016-26-7919 93 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18131 Slade School Road 20860 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. PO NOT use revised CLUNG WULLTOR
DUVISION OF NUTSING 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Public College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Health Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George L. Stanford Marie B. Linsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter H.L. Stanford - Nephew 6113 Turvey Loop E. Dublin. Ohio 43016 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 \(\mathbb{Z}\) Cremation 3 \(\mathbb{D}\) Removal from State Ft. Lincoln Crematory 08/23/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 1401524 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ INGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 X No ed by the a detached f 1 Yes 2 2 9 Unknown g Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires DEMENTIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🛛 No ည 1 Inpatient 2 ER/Outpatient 3 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To use Funeral Director: After composited filled in by the fun 2 Accident
3 Suicide
4 Homicide 1  $\square$  Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, deeth or arred at the time data and place

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ted Eric Howe, M.D.,

AUG 19 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

68760

Box

Records,

Division of Vital

33700

18100 Slade School Road, Sandy Spring, Maryland 20860

29d. Date signed (Month. Day, Year)

2011

August 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death MATG 16 2011 Physician/ 6:34 P CHARLES WILLIAM SCHILLINGER, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Country) Tllinois Months Days Hours Min. (Month, Day, Year 322-34-0709 68 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director VA 1 🗆 Yes 2 🔀 No Fairfax Burke 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code "natural", or items 23a o Funeral 6211 Falcon Landing Ct. USA 22015 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or DateVietnam 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Northrop Grumman College (1-4 or 5+) Elementary/Seconday (0-12) permit, Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the Aonce. Director of Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Schillinger Marion Zack 19a. Informant's Name/Relationship (Type, Print)  $\,\,$   $\,$   $\,$   $\,$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 22015 Barbara M. Schillinger/ 6211 Falcon Landing Ct., Burke, VA Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of August Quantico National 1 Burial 2 Cremation 3 Removal from State Triangle, VA 4 Donation 5 Other (Specify) 2011 Cemetery Signature Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 hos For 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ CHRONIC LYMPHOCYTIC LEUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conse juence of): executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page performed? 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မ this hours after death.

neral Director; After this I filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: injury 1 😾 Natural 5 Pending work 1 🗋 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 0101248380 (VA) MI 12011 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar TIDA KUMBALASIRI,

31. Date filed (Month, Day, Year) AUG 19 2011

LT

MC USN

2. Registrar's Signature

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

FRANTILIN SCOTTON III CHANG 11-06097 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 28527 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner 0030 hrs Richard Franklin Scotton, August 13, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 15708 Holly Grove Rd Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In yrs. last birthday) Foreign Country) Days Director Hours 579**-**19-7532 1 X M 2 F 26 July 01.1985 DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 X No Maryland Montgomery Silver Spring Director 10e. Street and Numbe 10f. Zip Cod 10g. Citizen of What Country? 12800 Theresa Drive 20904 U.S.A Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? death 1 X Never Married White, etc. Yes 2 X No African-American If Yes, Give Year Yes 2 X No specify: þ 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturilying or other tranmarit event, the Medical Exam 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Richard Franklin Scotton Andrea B. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Franklin Scotton/Father 12800 Theresa Dr. Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 08/20/2011 Silver Spring, MD Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring. MD20904 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be execu Physician/Medical physician a UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Day Pregnant at time of Other (Specify) Yes 2 No 9 Unknown signed by the a Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ σ, Yes 2 V No 3 Probably 4 Unknown Completed Records, peen 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 ✓ Yes To the Hospital or Attending Physician: within 24 hours after death completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one Division of Vital examiner? Hospital: 1 Other<sub>4</sub> Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aug 13, 2011 Occupant of auto involved in collision Natural 0022 hrs within 24 hours after death To the Funeral Director: Pending Yes 2 V No 2 🗸 Accident Investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 15708 Holly Grove Rd, Silver Spring, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 13, 2011 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registra DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 28528 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 3. Time of Death 7:00P. 2. Date of Death Physician/ Amelia Smercak August 18 y 2011ea Medical 4a. Facility Name (if not institution, give street and number)
Renaissance Gardens Riderwood Village 4b. City, Town, or Location of Death Silver Spring Examiner 4c. County of Death George's Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 87 112-16-0366 OCt. 30, 1923 New York, NY Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director items 23a or 28a-f s ser must be notified Silver Spring Maryland Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States death with 3160 Gracefield Road, #1532 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten Examiner ı Black, White, etc ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify 3 XWidowed 4 Divorced Specify: "natural" Completed al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 of 5+) Elementary/Seconday (0-12) Montgomery County Library Assistant Ith and Mental Hygie 27 is marked other r traumatic event, the Be , Mother's Name (First, Middle, Maiden Surname) rancesca Wolenski 17. Father's Name (First, Middle, Last) 18, Mother's Name (r.) Francesca မ Anthony Perec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Codel 13203 Taney Drive Beltsville, Maryland 20705 ent of Health a it: If item 27 is y or other trai Thomas Hickey -son in law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or SilverSpring, Maryland Gate of Heaven Cem. 8/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonard WoresBorgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 2Vears Ph\_sician/ End Stage Dementia disease or condition Medical resulting in death) **Examiner** 8years ASCVD Sequentially list conditions, if any, leading to immediate gauss. Enter Undanying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Li Fetal deal
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown ō Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has, page 2 performed 2 XNO this certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Deatl 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tem 2) (Type, Print)

Julatine Harding, NP 3110 Grace field Road Silver Spring, Maryland 20904

State

Registrar

31. Date filed (Month, Day, Year,

AUG 23 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Ralph S. SIMON August 21 2:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Brighton Gardens Assisted Living 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 200-20-0275 Months Days Hours Min. Pennsylvania Director 1912 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Rockville Mary land Montgomery 10e. Street and Number ō 10g. Citizen of What Country? 20852 Funeral 5550 Tuckerman Lane items 23a United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Self-Employed (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Furniture** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Goldie Yochelson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Joseph Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 12504 Meadow Farm Road, Potomac, MD Richard S. Simon, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Pittsburgh, PA 4 Donation 5 Other (Specify) Tree of Life Memorial Park 08/23/11 21. Signature of Fu era Servio Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part 1 Exert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Cardiomyopathy Ph, si\_ian/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Urosepsis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying b Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed Yes 2 has certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Livina injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-27660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alpana Goswami, M.D., 11125 Rockville Pike, Suite 110, Rockville, MD

Registrar

State

31. Date filed (Month, Day, Year)

AUG 23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:00 P August 19 2011 2011 Physician/ Leon SALZMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Bedford Court If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Poland Social Security Numbe 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday **Funeral** Hours 1 X M 2 □ F 92 077-26-3585 Director 27 1918 Aug Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🂢 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20906 Funeral 15100 Interlachen Drive #110 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Men's Store 0wner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Yocheved 2 Leizer Salzman permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) Estelle Salzman, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 Interlachen Dr., #110, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Method of Disposition Date 1X Burial 2 Cremation 3 X Removal from State David Memorial Garden 08/22/11 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) TOrchinskys Hetsirew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final heart C on tive

Due to (or as a consequence of): Ph\_sician/ vead Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Universiting Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown been signed by the s 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: After injury 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. Accident Investigation the 6 Could not be To the Hospital or Att within 24 hours after de To the Funeral Directo Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar 29a. Certifie

(Check

only one)

29b. Signature and title

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Complete Completed Cause of death (Item 23a) (Type, Print)

Complete Completed Cause of death (Item 23a) (Type, Print)

North Leisure World Blad Silver Spring mod 09 actions to the complete Comple

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 06/2

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Eleanor Jane Sinnott 10 0407 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death <u>Peninsula Regional madicul</u> X115bun Cente Wicomico June 30 Year If Under 24 Hrs.
Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Country) **Director** 216-30-2950 June MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Wicomico Delmar 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8923 Executive Club Drive 21875 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Black and Decker Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ G. Willard Gorsuch Troxell Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Sinnott/husband 8923 Executive Club Drive, Delmar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Evergreen Mem. Garden 08/15/2011 Finksburg, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final inh Physician disease or condition resulting in death) schenia Medical Due to (or as a consequence of). Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown the detached 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 L'Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 📝 No ပ 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 🖳 Natural injury 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) WIL D62107 8/10/11 12 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State

Registrar

Wilkite

AUG 1

31. Date filed (Month, Day, Year)

100 E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stickel Maryann Elizabeth 4:45p M 2011 Ana Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Westminster Dove House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 X F Davs Hours Min. (Month, Day, Year) 10/16/1930 215-28-757 Director 80 Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Hampstead MD 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Learnit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "recognity injury or other traumatic." USA 21074 Green Haven Way 2206 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 🗆 Yes 2 🖵 No If Yes, Give Specify white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) medical comptroller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pearl Kelly Charlie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2022 Garrett Road, Manchester, MD 21102 Diana Blosser, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 8/15/11 Hampstead, MD 4 Donation 5 Other (Specify) Carroll Cremation Eline Funeral Home 21. Signature of Funeral Service Licensee M0074 22. Name and Address of Facility 934 S. Main Street, Hampstead, MD 21074 0 mmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Month Year Pregnant at time of death 9 Unknown P.O. I s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 MNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number WJI 3 mpleted cause of death (Item 23a) (Type, Print 2 STONER AUE W JMINSTER WOZIIST

State

Registrar

31. Date filed (Month.

AUG 1

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Je outs croug Zafl Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🛛 F 2/13/1929 245 40 3627 NC **Director** 82 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Maryland Director Suitland 1 🛚 Yes 2 🗆 No Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 20746 3940 Bexley Place Apt. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 X No Specify. If Yes, Give 3X Widowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene.
It is marked other than "natun traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Hospital& Private Nurses Assistant 12th Be 18. Mother's Name (First, Middle, Maiden Surname) Mamie High 17. Father's Name (First, Middle, Last) ည Robert Mial 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Hope Pryor/Granddaughter 914 Pine Forest Ln.Upper Marlboro,MD 20774 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of I Important: If it any injury or or on once. cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 8/23/2011 4 ☐ Donation 5 ☐ Other (Specify) High Family Cem. Zebulon, NC 22. Name and Address of Facility William Toney's Funeral Home 21. Signal of Funeral Service Licer ambelly P.O.Box 430 Spring Hope, NC 27882 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician mintel disease or condition Medical resulting in death) **Examiner** divoul monder if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner burial-tran Due to (or as a consequence of): resulting in death) Last led by the attending physician detached for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to predical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred injury 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number D0068207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503

State

Registrar

31. Date filed (Month, Day, Year)

8/16/11

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lewis - O . Steward 9118 AM August 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Upper Marlboro 9952 Rosaryville Rd. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country Wisconsin Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 X M 2 □ F March 8, 1924 218-16-0680 Director 87 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director ms 23a or 28a-f s must be notified 1 Yes 2XX No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 U.S.A 9952 Rosaryville Rd. "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No WWIII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: 3XXWidowed 4 ☐ Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Sears & Roebuc Service Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas L. Steward Mildred Sanborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9960 Rosaryville Rd. Upper Marlboro, MD 20772 Beth Ann Carroll (Executrix) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 XXBurial 2 Cremation 3 Removal from State MD Veteran's Cemetery August 25, 2011 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 Signature of Funeral Service Lice 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bindder Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Fried Inderlying Cause (Disease or linjury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural 5  $\square$  Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MN 49 AMM 1) 29d. Date signed (Month, Day, Year) 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-S Ryapaks, MID. 2835 SMIM N Baltimore MD 21204 57R 31. Date filed (Month, Day, Year)
AUG 2 2 2011 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ August 24, 20 led 6:05 M Helen Corrina Thrasher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Egle Nursing and Rehab Center Lonaconing 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) September 23, 1926 Country) Maryland 1 🗆 M 2 🔀 F Days Hours 215-26-7675 Yrs. Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director Yes 2 No Midland Allegany Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21542 USA 14903 New Georges Creek Road, SW 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importantt: If item 27 is marked other than "any injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Coleman David Llewellyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 791 Crandon Boulevard, Key Biscayne, Florida, 33149 Ernie Thrasher - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date August 26 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State rostburg Memorial Park Frostburg, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): ned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 7 No
9 Unknown Month Day 4 Pregnant : 9 Unknown 5 Other (specify) Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' autopsy page 2 Yes 2 No 1 Yes 2 KNo After this certificate 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 2 🔯 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 🛭 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

NLS

Sidhu, MD

31. Date fled (Month, Day, Year) AUG 25 2011

82, Registrar's Signature

Road Cumberland, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Leona Thomas Mae 2011 8:30 A 13. August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cumberland 513 Henderson Avenue Allegany Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 213-24-7417 Months 1 🗆 M 2 💢 F Min. 05/30/1924 87 Pennsylvania Director Usual Residence of Decedent 23a or 28a-f show st be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21502 **Examiner must** 513 Henderson Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 📈 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurant Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bennett Emma G. Wringler 0sburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Henderson Avenue, Cumberland, MD 21502 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ronald W. Michael / Son 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 08/16/2011 Cumberland, MD Greenmount Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home. P.A. Sign fure of Funeral Service Licenses 21502 404 Decatur Street, Cumberland, MD enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician CIRRHOSIS OF THE LIVER disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 performed 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending after death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 1 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0014865 August 15, 2011

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month

32. Registrar's Signature (

Robustiano J. Barrera, M.D., 200 Glenn St, Ste 302, Cumberland, MD

21502

30. Name and address of person who completed cause of death (liem 23a) (Type, Print)

AUG"15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August የ 20 ነ 2:54 A M Physician/ Benjamin C. Thompson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 9. Birthplace (State or Foreign 8. Date of Birth '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Country) DC 5. Social Security Number **Funeral** Min. 1 🔀 M 2 🗆 F 8/97/10944 578 56 5036 67 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 20017 81 Hawthorne Court NE items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Black, White, etc. Armed Forces?

1 2 Yes 2 No or. Completed by 1 Never Married 2 Married Specify:Black If Yes, Give 1963-65 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the 1 Office Clerk Government 10th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Lillian Thompson William Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hawthorne Ct.NE Washington, DC 20017 Brenda J. Thompson/ Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Suitland, MD WashingtonNat'l. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses MD20601 2294 Old Washington Rd.Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 Sis ₽hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No for 4 Pregnant : Pregnant at time of death signed by the at d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed s certificate has t director, page 2 s death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Watural work' 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Routa Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0060100 D M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BB lod 831 Brrs Sul Film iby 31. Date filed (Month, Day, Year) AUG 2 2 2011

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State AMEND#19a/b+20bperFH, 8/29/11; BW, MbCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:43AM NOV n 101 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. Cify, Town, or Location of Death Georges Communit Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** South Carolina Days 1 M 2 M Months Hours Min Director 187-42-4096 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Carrollton 1 Yes 2X No New Prince George MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6108 20784 86th Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Important: If Item 27 is marked other than "natural", or ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 1 Yes 2 No Specify Specify. Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Waittre Be 17. Father's Name (First, Migdle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ernon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Glen
21061 19a. Informant's Name/Relationship (Type, Print) (daughter) Kamos permit. Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 732 G1 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Sepsi Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Respirator Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ial-trapsit or Attending Physician; The law requires that the death certificate be executed Acute myocardic intarch'on that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burid Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month 1 ☐ Yes 2,⊭ 9 ☐ Unknown the detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ER/Outpatient 3 DOA Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

3

State

FASIL

31. Date filed (Month, Day, Year)

AUG 18 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. ALEMU, MD

D65909

8118 GOOD LUCK ROAD, LANHAM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:30 а м 2011 Lena Bessette Vargas August 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. St. Thomas Moore Nursing & Rehab. Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Country) Vermont **Funeral** Dec. 26, 1922 1 M 2 K Director 008-14-1720 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No MD Garrett Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral 20896 USA 10706 Keswick Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mentlal Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes. Give 3 Wildowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Nursing Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Dorilla Boudreau Leon Bessette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10706 Keswick Street, Garrett Park, MD 20896 Jose Emilio Vargas/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify)  $01\overline{1}$ Silver Spring, MD Prancis J. Collins Funeral 500 University Blvd. W., 21. Signature of Funeral Service Lice Home Inc. Silver Spring, MD 20901 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ue to (or as a consequence of): Exami burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician doe detached for use as the burish Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No Yes 21 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work?
1 Yes 2 No 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar Ajit Kurup, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10063651

1835 University Blvd. East, #208, Hyattsville, Md 20783

17/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Day Physician/ 2011 12:05 PM Shirley E. Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fort Washington Hospital Fort Washington 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday **Funeral** 08/13/1949 1 □ M 2🗶 F Washington DC Director 62 579-66-1469 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 😾 Yes 2 🗆 No DC Washington None 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Funeral items 23a USA 20020 4029 Alabama Avenue S.E. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ☐ Yes 2 XNo 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🗓 No Specify. Specify: If Yes, Give "natural", 3 - Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mex College (1-4 or 5+) Elementary/Seconday (0-12) Walter Reed Hospital Secretary 12th Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Carter Levi Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4029 Alabama Ave., S.E. Washington, DC 20020 Mary Day/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory08/20/2011 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such Interval Between shock, or heart failure. List only one cause on each lin Onset and Deat Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Cother (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death ed by the a detached f a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No this certificate 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **Q**No 1 Yes 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA ၀ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Box 68760

P.O.

State

Registrar

DHMH 17 Rev 7/2009

Livingston Road Ft. Washington, MD 20744

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

<u>Amir Mirza-Alikhani</u>

11711

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	St	ate of Ma	aryland	-				Mental	Hygien	ອ ວິດ	1-1	28541
		State Registrar	" 1			Cer	tificate	of De	eath	0.5-1-	Reg. N	40	1 1	
Physicia	n/	1. Decedent's Name (First, Mid								2. Date of	1 0	ay	Year	3. Time of Death 7:45 P M
Medic		Joseph E.  4a. Facility Name (if not instituti		Wooten	1		4b. City To	own or Lo	ocation of Dea		17/20		y of Death	1,0,1,0
Examin	er	Holy Cross Ho		aria riamboly					Spring				gome	
Funeral		5. Social Security Number	6. Sex		e (In yrs. las	st birthday)	If Under 1	Year I	f Under 24 Hi Hours Mi	rs. 8. Date of	of Birth		9. Birt	hplace (State or Foreign
Director		244-68-3778	1 □ <b>X</b> M	2 L F	66	Yrs.	Months	Days	Hours	12/	h, <i>Day,</i> Year, 19/19	44		t County, NC
ld It	_	Usual Residence of Decedent  10a. State 10b. Cour	ty		10c, City	, Town or Loc	ation							10d. Inside City Limits
arylar a-fsł fied a	ecto													1 X Yes 2 □ No
the M or 28 e noti	ğ	DC 10e. Street and Number			I Wa	<u>ashing</u>	10f. Zip (	Code			10g. (	Citizen of	What Co	untry?
with s 23a ust b	Funeral Director	1231 Delafiel	d P1 N	.E.				200	)17			U.S.	Α.	
death item: ier.m		11. Marital Status	A	Vas Decedent E rmed Forces?	Ever in U.S.	. 13. V	Vas Decede Yes, specif	nt of Hisp y Cuban,	anic Origin? ( Mexican, Pue	Specify Yes of erto Rican, etc	r No- .)		ce - Amei ack, White	rican Indian, e. etc.
after or samir	d b	1 ☐ Never Married 2 🛣 N 3 ☐ Widowed 4 ☐ Divord	, If	Yes, Give	No	1	☐ Yes 2	No.	Specify:			Specify	v.	
atura cal E	Completed		dent's Education	ear or Dates. on	- 1	16a. Deced	lent's Usual	Occupation	on		16b.	Kind of E	Business	ack Industry
n 72 h an "n Medi	dm	(Specify only his		<i>mpleted)</i> ollege (1-4 or 5	5+)	(Give F life. D	kind of work O NOT use i	done dur etired)	ing most of w	orking				
withii giene ger th		12th				Sma1	1 Eng		(echani					vate
ified tall Hyad outh	To Be	17. Father's Name (First, Middle	, Last)					1		lame (First, Mi			,	
y ra			looten	7.40		1			Viola			atum		- C- d-\
2 sho th and 27 is r		19a. Informant's Name/Relation Annette Woote		•						Rural Route N				C 20017
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition				ace of Dispo	sition (Name	e of	-	Date				Town, State
age age intention		1 🖺 Burial 2 🗆 Cremation 4 🗆 Donation 5 🗆 Othe		oval from State	' <b> </b>	emetery, cren nwood				/22/201	1 Wa	shin	gton	. DC
partition permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funer Joery			101.01									neral Home
	12											gcon	, 100	20011
		23a. Part 1. Enter the disease shock, or heart failure. Li:	or complications only one cal	ise on each line	e.									Approximate Interval Between
Physician/	1	Immediate Cause (Final disease or condition	a				Mid1	le Ce	erebra	l Arter	y Inf	arct	ion	Onset and Death Weeks
Medical Examiner		resulting in death)		Due to (or as			i	n a + h +						years
	er	Securifically list conditions if any, leading to immediate	ь –	Due to (or as		e Card	Tomyo	patny	/				_	years
rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury	5			ibrill	ation							years
be executed sician and burial-transit	Ē	that initiated events resulting in death) Last	C	Due to (or as	a consequ	ence of):						_		
te be nysicia	dical		d											
ertifica iding pl	Physician/Me	IF FEMALE:	220 1	f yes, outcome	of prognar	201								
death ce	cian	23b. Was decedent pregnant in the past 12 months?	1	Live Birth Pregnant a	2 Feta	Ideath 3	Ectopic p						Date of de Nonth	Day Year
the a	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown	at 11110 01 0									
that the ned by deta	y PI	Part II. Other significant cond Seizure Disc	itions contrib	uting to death b	but not resu	ulting in the L	nderlying c	ause giver	n in Part I.	23e.				the cause of death?
Lo,	Completed by	Seizure Disc	ider,	пурегсе	:112 TOI	, 001	Ollary	ALCO	- Y	- 10	1 🗌 Yes	2 <b>X</b> No	3 □ F	Probably 4 Unknown
ecolus, law requires has been sig	plet	Disease								_	. Was an autopsy		prior to	utopsy findings available completion of cause of
The la	E O							_		1 🗆	performed Yes 2	? No	death?	s 2 No
VILAI ysician; s certific director,	Be (	25. Was case referred to medic examiner?	Hospi	tal:				26. Plac		heck only one				
Physi Physi this o	<u>ا</u>	1 Yes 2 ANo 27. Manner of Death		1 delinpat 8a. Date of inju		ER/Outpatier 28b. Time of		Bc. Injury a	4 ☐ Nursin	g Home 5	Residence			cify)
ding Pl th. After th	cate	1 Natural 5 ☐ Per		(Month, Da		injury	M	work?	es 2 🗆 No	200. 200	STIDE HOW III	july occu		
VISION or Attendir frer death. irector: Af	Certificate:	3 Suicide 6 Co	ild not be	8e. Place of Inj			eet, factory,	office					ber or Ru	ural Route Number,
tal or rs afte				building, et	ic. (apecity)					City	or Town, Sta			
Hospi 4 hou Funer ted fill	Medical	(Check 2 Medic	al Examiner: (	: To the best of	examination	and/or inves	tigation, in n	noinigo vn	, death occurr	ed at the time,	date and pla	ace, and o	due to the	cause(s) and manner stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 Certify 29b. Signature and title of cert	ing Nurse Pra	ctioner: To the	e best of my	/ knowledge,	death occur	red at the t	time, date and	place, and du	e to the cau	se(s) and	manner as	s stated. th, Day, Year)
<b>5</b> ≥ <b>6</b> 8		Barbara	ຄ	mich,	Pens	INN			0654	195	250.	08	1	12011
		30. Name and address of pers						ر ر	7 23 7	0.0		U	( (	10-11
C 8.		Barbara St						st G	len Rd	Si	lver S	Spri	ng, M	1D 20910
Sta	te	31. Date filed (Month, Day, Yea		32. Registr			-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:40AM Flizabeth Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Senier Living of Snau Hill Harrison Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age in vrs. last birthday) Funeral 1 M 2 M F Hours Country) Director 219-05-9105 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo Green back wille ccamack 10g. Citizen of What Country? 10e, Street and Number Funeral 38994 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 Volume Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7/2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) M. Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hmond, VA Hamilton Esther Floud Vaughte 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 8-20-2011 4 ☐ Donation 5 ☐ Other (Specify) Greenbackville Cemetery Greenbackville Chincotrogue, UA 2333c 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ar disease or condition resulting in death) ens Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) and I-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) 1 ☐ Yes ∠ ☐ g ☐ Unknown 9 I Inknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law autopsy page 2 death? 1 ☐ Yes 2 ☐ No certificate Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al Investigation Accident the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 08-17-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DH 1604-Market 54. /ocomo 31. Date filed (Month, Day, Year) AUG 1 9 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Jr. Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death City Examiner Calvert emoria Hospita 9, Birthplace (State or Foreign Birthpic Country! Social Security Number If Under 1 Year 8. Date of Birth 6. Sex . Age (In vrs. last birthday) **Funeral** Days Feb. 2, 19,23 1 M 2 D F Z Yrs. 579-26-8344 Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD Solomons 1 Yes 2 No Calvert 10f. Zip Code 20688 10g. Citizen of What Country? 10e. Street and Number by Funeral 11450 Asbury Circle Unit 130 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
White 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Interior Designing Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Interior Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cooley 9 Herbert С. Wade, Sr. Dorothy 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 2510 Chinquapin Ridge Ct. Prince Fred., MD 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Richard Wade/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/10/2011 Metro. Crematory Alexandria, 4 Donation 5 Other (Specify) Funeral Home, P.A. Prince Fred., MD20678 22. Name and Address of Facility Sewe11Signature of Funeral Service Licenses 1451 Dares Beach Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last as the burialphysician Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? ģ Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown signed by a Part II. Other sfgnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer (Month, Day, Year) injury 1 Natural 5 Pending death. M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number after 4 Homicide determined building, etc. (Specify) City or Town, State 24 hours a Funeral L Hospital Medical 🗄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifie

drw 10+1

State Registrar person who completed cause of death (Item 23a) (Type (Print)

WALTERS, JUANITA Boltimore Manyland 21215-0036

		1	State of Maryland / Department of Health and Mental Hygiene 2011 28544  1-State Registrar  Certificate of Death  Reg. No.									
ı	Physicia		1. Decedent's Name (First, Middle, Last,  Juanita		alter			2. Date of De Month Aug.	ath Dav	O 1 1	3. Time of Death 10:36 A <sup>M</sup>	
	Medic Examin		4a. Facility Name (if not institution, give s Calvert County	treet and number) Nursing Cen	nter	4b. City, Town, or Prince	Location of Fre		4c. Coun	ty of Death 1 ver		
	Funeral Director		5. Social Security Number 6. Sec 2 2 7 - 1 2 - 7 9 2 1	7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da Apr. 1	th 5,1923	9. Birth Cour	place (State or Foreign htry) VA	
	rland f show d at	tor	Usual Residence of Decedent  10a. State  10b. County		y, Town or Lo		- 1-				10d. Inside City Limits	
	the Mary a or 28a-f be notifie	al Director	MD Calve  10e. Street and Number 420 W. Dares B		rince	Frederi 10f. Zip Code 20678	LCK		10g. Citizen o	f What Cou	1 ☐ Yes 2基 No ntry?	
936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at anongo.	by		12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba	Decedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Amer Black, White Specify: Whi				can Indian, etc.	
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12) 1 2		(Give life. D	dent's Usual Occupi kind of work done o O NOT use retired) memaker	ation during most o	of working	16b. Kind of Business Industry  Own Home			
land 2	be filed w ental Hygi rked other ic event, i	a l	17. Father's Name (First, Middle, Last)	Mills			18. Mother Virg	's Name (First, Middle inia	, Maiden Surnai J	ones		
Mary	d 2 should alth and N 1 27 is ma er traumat		19a. Informant's Name/Relationship (Ty) Lawrence H. Wa1		19b. Maili 7 2 2	ng Address (Street a	and Number	or Rural Route Numb nd Ct.	er, City or Town, Midlot	State, Zip hian	Code) , VA23112	
imore	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1	Removal from State	cemetery, cre 1 e Me	psition (Name of matory or other place m . Park	18	Date / 11 / 2011	20c. Location	erfi	eld. VA	
Balt	permit. Departi		21. Signature of Funeral Service License	evell	2 1	2. Name and Address 45 0 Dan	ss of Facility	Sewell A each Rd	11era/	HOM	e, f.A.	
- <b>+</b>	Pnysician/ Medical Examiner	er	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ilications that caused the deat the cause on each line.  a. Due to (or as a consequence)  Due to (or as a consequence)	Clene uence of):					S+ (2.50	Approximate Interval Between Onset and Death	
09/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	CDue to (or as a conseq	uence of):							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 10 No 9   Unknown   1   Live Birth 2   Fetal death 5   Other (specify)								23d. Date of delivery Month Day Year		
ls, P.O	uires that the signed by all the detail	ed by Pl	Part II. Other significant conditions co	Heart	Freel	1/20		1			the cause of death? obably 4 Unknown	
Division of Vital Records, P.O.	The law requate has been page 2 shou	Complete	Chronic or Atsial fil	orille tion	Air	way c	live	24a. War aut per 1  Yes	formed?	death?	opsy findings available completion of cause of	
ital	sician: certific irector,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpotic	Oth	or /	n <i>(Check only one)</i> rsing Home 5  Res	sidence 6 🗆 C	ther (Speci	(fy)	
of/	ing Phy fter this uneral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Injur work	y at </td <td>28d. Describe</td> <td>how injury occ</td> <td></td> <td></td>	28d. Describe	how injury occ			
ivisior	I or Attending I after death. Director: After I in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st		Yes 2 □	28f. Location	(Street and Nur own, State)	mber or Rur	ral Route Number,	
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Exami	sician: To the best of my know ner: On the basis of examination the Practioner: To the best of m	on and/or inve	stigation, in my opini	on, death occ	curred at the time, date	and place, and	due to the	cause(s) and manner state	
	Northi Voithi	_	29b. Signature and title of certifier	. c. Sw	-ava	29c. Licens	506	553	29d. Date sig		2011	
	KW3		30. Name and address of person who of 5 851 - Day	completed cause of death (Iter	n 23a) (Type,	1 41	ANRO	C. S	DRY	) NA	20757	
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 12 2011	32. Registrar's Signa	ature	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Daniel H. Wise 10:16 AM August Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year May 6 1 🗙 M 2 🗆 F Tiffin. Ohio 293-48-2700 54 1957 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral items 23a USA 21409 436 Cranes Roost Court death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. "natural", or \$ 1 X Never Married 2 Married Maryland 21215-0036 hours after Specify: White 1 ☐ Yes 2 🗓 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Lieutenant Colonel 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important if item 27 is marked other than any injury or other trainment. 5 College (1-4 or 5+) Elementary/Seconday (0-12) USAF Reserve Be 18. Mother's Name (*First, Middle, Maiden Surname*) Elizabeth Hartzler 17. Father's Name (First, Middle, Last)

Leon Milton Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 331 Cardinal Glen Circle, Sterling, Va. Annie W. Nations/Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 8/17/11 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) al Swice Licensee <sup>22. Name and Address of Facility</sup> George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 21. Sign 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): that the death certificate be executed burial-transi and Due to (or as a consequence of) ũ resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Cther (specify) Live Birth 2 - Fetal death in the past 12 months? Year Pregnant at time of death signed by the a Yes 2 No g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 3 Probably 4 Unknown 1  $\square$  Yes No 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s death? 2 No 1 Tyes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2X No ER/Outpatient 3 DOA ျ 1 Inpatient 2 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Dettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one title of certifier 29d. Date signed (Month, Day, Year)

20 State

Registrar

Stuart E. Selonick, 31. Date filed (*Month, Day,* Year) **AUG 1 8 2011** 

M.D. 2003 Medical Pkwy., Ste 210, Annapolis, MD 21401 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8/10/11

State of Maryland / Department of Health and Mental Hygiene 28546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:59 P M Lawrence Glen Whipple 2011 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours August 25,1925 Washington 542-30-2868 85 **Director** Usual Residence of Decedent or 28a-f show notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 🗌 Yes 2 🗶 No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ō er than "natural", or items 23a of the Medical Examiner must be Funeral United States 18424 Flower Hill Way death v 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married ð Maryland 21215-0036 hours after Specify: Caucasian 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 3 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) La Electrical Engineer **US** Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Whipple Flossie Callbeck Wesley S. Whipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 18424 Flower Hill Way, Gaithersburg, Maryland 20879 <u>Margaret Garay</u>, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 8/22/2011 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signatu of Funeral Service Licensee MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Olle to for as a consequence of any leading to in ned cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the buriant Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day Pregnant at time of death the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 5 Failure 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an cate has I page 2 s autopsy certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes မ 12 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 62 435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular & Suite 2 Rocky, lie, MD 20850 Elsayyad MD Sayed 31. Date filed (Month, Day, Year, 32. Registrar's Signature State AUG 18 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

35

Q

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Ma		partment of He ertificate of De			2011	28547
	Division	_	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	Physicia Medic	al _	Clarence Edward White				08		3:45 A <sup>M</sup>
Š	Examin	er ²	Aa. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of Dea	ıtn
-	Funeral	£	381 Biggs Highway  5. Social Security Number   6. Sex   7. Age	(In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	h 9. Bi	rthplace (State or Foreign
	Director		215-34-6974 1 x M 2 □ F	77 Yrs.	Months Days	Hours Min.	10/29/	1933	ountry) WV
	d tow	ь н	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or	Location				10d. Inside City Limits
	arylan a-fsh fied a	Director	MD Cecil	Rising	Sun				1 ☐ Yes 2 😿 No
	or 28		10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	is 23a	Funeral	381 Biggs Highway		21911			USA	
	death r item iner n		11. Marital Status  12. Was Decedent E Armed Forces?		<ol><li>Was Decedent of His If Yes, specify Cuban</li></ol>	panic Origin? (Spe , Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
38	s after al", o Exami	d by	1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ I If Yes, Give Year or Dates.	/o	1 ☐ Yes 2 🕱 No	Specify:		Specify: W	hite
2-0	hour natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occupative kind of work done du	tion uring most of work	ing	16b. Kind of Busines	s Industry
21215-0036	hin 72 ne. <b>than '</b> ie Me	luo,	Elementary/Seconday (0-12) College (1-4 or 5	+)	o. DO NOT use retired) Wner / Opei	rator		Service	Station
d 22	ed wit Hygie other ent, th	l as l	11. Father's Name (First, Middle, Last)				e (First, Middle,	Maiden Surname)	
lan	l be fil lental rked tic ev	욘	Charles White			Anna Bo	ostic		
Maryland	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street ar				
≥,	and 2 lealth em 27 her tr		Betty I White - wife  20a. Method of Disposition		Biggs High		Date Sur	20c. Location - City	
Jor	nt of h		1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	cemetery, o	crematory or other place k Cemetery	)		Calvert, N	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Roseball	22. Name and Address	s of Facility	R.T.Foar	rd Funeral	HOme, PA
ñ	Dep Imp any		Kuchand L Good	lie.	111 S. Que				21911
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	he death. Do not	enter the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	hynician/	į.	Immediate Cause (Final disease or condition resulting in death)	ng Ca.	neer				Onost and Dean
-	Medical Examiner	П	Due to (or as a	a consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):					
	outed nd ransit	Examiner	Cause (Disease or linjury that initiated events						
	cate be executed physician and s the burial-transit	al E	resulting in death) Last Due to (or as a	a consequence of):					
200	cate b physic	edical	d						
89	ath certifica attending p	In/M	IF FEMALE: 23c. If yes, outcome	of pregnancy	3 Ectopic pregnanc	v		23d. Date of	
Box 687	death	Physician/M	1 Yes 2 No 4 Pregnant a	t time of death	5 Other (specify)			Month	Day Year
P.O.	at the	Phy	9 Unknown  Part II. Other significant conditions contributing to death by	out not resulting in t	he underlying cause giv	en in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
S, P	requires that the dea been signed by the should be detached	Completed by					1,2	Yes 2□No 3□	Probably 4 🗆 Unknown
ord	requi	lete					24a. Was		autopsy findings available to completion of cause of
3ec	The law sate has page 2 s	E O		-			perf	ormed? death	? Yes 2 🗆 No
Tal F	i <b>cian:</b> The certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Che			
₹ VI	ding Physician: 1 th. After this certifics funeral director, p	은	1 ☐ Yes 2 ♣No Hospital: 1 ☐ Inpati 27. Manner of Death 28a. Date of inju	ent 2 ER/Outp	atient 3 L DOA	4 ☐ Nursing F		idence 6 Other (Sp.	pecify)
0 0	nding of the street of tuner	cate	1 XNatural 5 ☐ Pending (Month, Da 2 ☐ Accident Investigation	y, Year) inju	ıry work	? Yes 2□No			
Division of Vital Records,	r <b>Attendii</b> er death. re <b>ctor:</b> At by the fu	Certificate:	0 Could not be		, street, factory, office		28f. Location ( City or To	(Street and Number or wn, State)	Rural Route Number,
<u>S</u>	iital or urs aft ral Dir lled in				41.		and due to the o	augo(s) and manner as	etated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of a only one) 3 Certifying Nurse Practioner: To the	vamination and/or i	nvestigation in my opinic	on death occurred	at the time, date	and place, and due to t	Te cause(s) and manner stated
	To the within To the compl	Σ	29b. Signature and title of certifier		29c. License		>/	29d, Date signed (Mo	
Ō			1 Mak		Dac	5400	ox	00000	NOIL
	SYN	4	30. Name and address of person who completed cause of	death (Item 23a) (Ty	pe, Print)	tool	STIP!	FM MI	21921
	0 11	oto-	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	riigit	T. J.	0	MILLIA	WI MI
	Sta Regist		31. Date filed Month, Day, Year 32. Registr	A. Day	les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. 101	Maryland / Depa			lental Hygi	iene					
		_	State Registrar	Cer	tificate of Dea	<u>ith</u>		eg. No.	11,28548				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Timothy Blake Wa	ırd			2. Date of Death Month		3. Time of Death Year 1				
	Medic Examin		4a. Facility Name (if not institution, give street and number,		4b. City, Town, or Loca	ation of Death	August	4c. County of					
		0.	555 Concord Street Unit	: P	Havre de	e Grace		Hai	rford				
	Funeral Director		5. Social Security Number 215-15-2591 6. Sex 1 ★ M 2 □ F 7. A	Age (In yrs. last birthday) 31 Yrs.	If Under 1 Year If U Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, June 23,	Year) 1980	9. Birthplace (State or Foreign Country) Maryland				
	p Mo		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits				
	arylan a-fsk fried a	Director	Maryland Cecil	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Port Depos	it			1 ☐ Yes 2 🔀 No				
	the M or 28 e noti		10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wi					
	h with ns 23a nust b	Funeral	98 Bentley Lane		219				S.A.				
9	is filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 ☒ Never Married 2 ☐ Married  1 ☐ Yes 2 iv	s? I' XI No	Was Decedent of Hispan f Yes, specify Cuban, Me I □ Yes 2 ☒ No Sp	exican, Puerto F	city Yes or No- Rican, etc.)		- American Indian, , White, etc.				
9	ours al ntural" sal Exa	Completed by	3 Widowed 4 Divorced Year or Dates		dent's Usual Occupation			16b. Kind of Bus	White				
-15	an "na Medic	mple	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 o	(Give )	kind of work done during O NOT use retired)	g most of workir	ng (	Citrus a	and Allied				
212	iled within 72 Il Hygiene. I other than ' vent, the Me		Six Yea	rs Fo	od Scientis				Maryland				
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed w of Health and Mental Hyg If item 27 is marked othe r other traumatic event,	To Be	17. Father's Name (First, Middle, Last) Blake Edward Ward		18.		(First, Middle, Ma a Kay T						
Mary	2 should th and M 27 is ma traumal		19a. Informant's Name/Relationship (Type, Print) Blake Edward Ward (fathe	\ I	ng Address (Street and N Bentley Land								
re,	1 and if Heal item (		20a. Method of Disposition	20b. Place of Dispo		<del></del>			City or Town, State				
<u>E</u>	Page ment o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	"~  West No	ttingham	08/	26/11	clora,	Maryland				
Balt	permit. Page 1 a Department of t Important: If ite any injury or of once.	47	21. Signature of Funeral Service Licensee	21903	me, P.A. -0766								
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each l	sed the death. Do not ente	er the mode of dying, su	ich as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death				
24	Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):										
-	Examiner		Due to (or a	as a consequence of):									
		iner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying	as a consequence of,:									
	be executed sician and burial-transit	dical Examiner	Cause (Disease or iinjury	as a consequence of):				<u> </u>					
_	ite be exe hysician he burial	calE	resulting in death, East										
160	icate l g phys is the	ledic	d										
Box 687	or Attending Physician: The law requires that the death certificate be executed after death. Interest. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	Physician/Me		h 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year				
P.O.	ires that the dea signed by the a id be detached f		Part II. Other significant conditions contributing to deat	h but not resulting in the u	underlying cause given in	n Part I.	23e. Did tot	pacco use contrib	oute to the cause of death?				
S, I	uires t in sign uld be	ed b					1 □ Ye	es 2 No	3 ☐ Probably 4 ☐ Unknown				
Score	law require has been si ge 2 should	Completed by					24a. Was ar autops perform	sv pi	lere autopsy findings available rior to completion of cause of eath?				
E Re	ysician: The la is certificate h director, page		25. Was case referred to medical		26. Place o	of Death (Check	perform 1 \(\sum \) Yes		Yes 2 No				
Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 🏋 No Hospital: 1 ☐ Inp	atient 2  ER/Outpatie	nt 3 DOA Other: 4	I ☐ Nursing Ho	Family me 5 - Reside	s Second ence 6 🕅 Other	lary Residence				
n of	ding Ph th. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	njury 28b. Time of injury	f 28c. Injury at work?		28d. Describe ho						
Division of Vital Records,	or Atten after dea Director: in by the	27. Manner of Death   1											
Δ	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best (Check 2 Medical Examiner: On the basis of	of examination and/or inves	stigation, in my opinion, de	leath occurred at	the time, date an	d place, and due	to the cause(s) and manner stated.				
	To the within ?	ž	only one) 3 Certifying Nurse Practioner: To t 29b. Signature and title of certifier	the best of my knowledge,	29c. License nur	mber			oner as stated. (Month, Day, Year)				
			· Var		D 5		7/	8/	7 271 "				
_	10		30. Name and address of person who completed cause of ASN Ku		Print) 510 Upp HRAV	er Ches	sapeake 4th F	loor, Ko	Pavilion 2 oom 409 zland 21014				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	back				,,				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 20 2011 Physician/ Mamie Margaret Wilt 10:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Frostburg Nursing and Rehab Frostburg Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec. 2 9. Birthplace (State or Foreign 5. Social Security Numbe 216–22–5459 **Funeral** 1 🗆 M 2 🗶 F Hours West Virginia Ť921 **Director** Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State Director MD Allegany Cumberland 1 X Yes 2 No 10f. Zip Code 21502 10g. Citizen of What Country? 10e. Street and Nun 10908 Thornwood Drive United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. white 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housework Homemaker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Franklin Albert Hattie Gertrude Roby Ray 2 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10908 Thornwood Drive, Cumberland, Maryland 21502 19a. Informant's Name/Relationship (Type, Print)
Doris Sullivan/daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 08/22/2011 1 🗆 Burial 2 🚾 Cremation 3 🗆 Removal from State Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wans 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Coronary Immediate Cause (Final Or year Physician/ en disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year 4 Pregnant Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ျှ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 - Residence 6 - Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: Natural Accider work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 021244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg Md 21532 Broadway Jesus TAN, 31. Date filed (Month, Day, Year) State AUG 2 2 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Nertificate of Death	Mental Hygien	2011	28550				
			Hegistrar  1. Decedent's Name (First, Middle, Last)	Timouto or Bourn	2. Date of Death	1 27	3. Time of Death				
	Physicia Medic		Anna Theresa Wachter		August 14	Day 2011 Year	2140 м				
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th				
	<i>•</i>		Carroll Hospital Center	Westminster		Carroll	_				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year Mar 10,	9. Bir	thplace (State or Foreign buntry) MD				
	Director		217-09-9365 1 M 2 M F 91 Yrs.		Mar 10, 1	1920	THD .				
	and show Lat	or	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
	Maryl 8a-f	Director	MD Carroll West	minster			1 ☐ Yes 2 🎦 No				
	a or 2	Ö	10e. Street and Number	10f. Zip Code	10g.		ountry?				
	h with	Funeral	1075 Wilda Drive	21157							
	r item		11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No~ Rican, etc.)						
38	at", o	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: V	White				
ŏ	hours natur lical 1	Completed	15. Decedent's Education 16a, Dec	edent's Usual Occupation	16b.						
218	in 72 e. nan "ı	m d		e kind of work done during most of worki DO NOT use retired)	ng \	on Paris	s 🖺				
7	l with ygien her th		12 Corp	orate Secretary			d Storage				
and	e filec ntal H ed ot even	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)					
Maryland 21215-0036	d Mer mark matic	Bonaventure von Paris  Theresa Anton  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									
$\mathbf{Z}$	2 sho Ith an 27 is trau				burg, Mary						
ē,	1 and if Hea item other		20a. Method of Disposition 20b. Place of Disp	position (Name of							
m 0	Page nent o nt: If ry or			ematory or other place) leart of Jesus 8/18	/2011 Dur	ndalk. Ma	arvland				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			22. Name and Address of Facilit							
<u>m</u>	89788		Jan K ASC	412 Washington Rd.	Westmins	ster, Maj	ryland 21157				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	Λ	- 1		Approximate Interval Between				
	hysician/	8 4	Immediate Cause (Final disease or condition	toatic Anovi	USM		Onset and Death				
	Medical Examiner		resulting in death)  Due to (or as a consequence of):								
		er	Sequentially list conditions, b. Due to for as a sonsequence of,								
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury				10d. Inside City Limits   1   Yes 2  No   No   No   No   No   No   No   N				
	execu an and ial-tra	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d								
876	tificat ingpl ast	Med	IF FEMALE:								
Box 687	th cer ttendi	ian/	in the past (2) londis:	Ectopic pregnancy							
ă	e dea the a	Physician/Me	1   Yes 2 No 4   Pregnant at time of death 5 g Unknown	Other (specify)							
Ö.	hat th ed by detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?				
s,	uires t n sign Ild be	q þe	COSONARY ASTERY OF	75036	1 🗆 Yes	2 No 3 🗆 F	Probably 4 Unknown				
orc	w requ	plet	,		24a. Was an	24b. Were a	utopsy findings available				
3ec	The law cate has page 2.9	Completed			autopsy performed*  1  Yes 2 X	? death?	L.				
a	ysician: is certifica director, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check							
₹	Physic this or al dire	၉	1 Yes 2 No 1 Inpatient 2 ER/Outpati		me 5 Residence		cify)				
n o	al or Attending Phy s after death. I Director: After this d in by the funeral c	Certificate;	27. Manner of Death  1. Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)  28b. Time injury		28d. Describe how in	jury occurred					
sio	Attender deat ctor:	rtific	2		28f. Location (Street	and Number or Ri	ural Route Number,				
Division of Vital Records, P.O.	al or / s after il Dire		building, etc. (Specify)		City or Town, Sta						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 ☐ <b>Medical Examiner:</b> On the basis of examination and/or inv								
)	the H hin 24 the F mplete	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge	, death occurred at the time, date and place	ce, and due to the caus	se(s) and manner a	s stated.				
			29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mon	th, Day, Year)				
U	WJL		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		X = 12.	100 00 100				
	1-		M. PANSURIYA 349 Mc	displan DR	west.	win	461 WIS122				
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	Registra	ar	AUG 1 6 2011 Seneus S.	Barke							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug. 19<sup>Day</sup> Physician/ 201°T 2:35 PM Aleine Edith Watson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worcester Berlin Atlantic General Hospital Birthplace (State or Foreign Country)
 DE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8-27. 1927 1 □ M 2X□ F Days Hours **Director** 83 214-32-0592 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Berlin MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21811 9478 Old Ocean City Blvd. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. b 1 Never Married 2 Married 1 Yes 2X No Specify. white 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Farm Poultry Grower 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Hitchens Minnie Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9466 Old Ocean City Blvd. Berlin, MD 21811 Joan Bennett- Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD Sunset Mem Park 8-24-11 22. Name and Address of Facility 21. Signature Funeral Service Liverse Burbage Funeral Home Street Berlin. 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to for use as the burial-transit that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 N No
9 Unknown Dav Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be ( 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Acciden 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the 1 only one

7

Œ

0

0

0

00

2

261-42

atson, Aleine

State Registrar

DHMH 17 Rev 7/2009

Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OSAM 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Chesapeake Hospice House Harwood Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Days Hours 09-07-1918 Maryland **Director** 220-09-0127 92 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Anne Arundel Rose Haven 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 652 Alder Place 20714 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian reced Forces?

Yes 2 \sum No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates. 1942-46 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Linotype Operator, Proofreader Printing & G.P.O. 12 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bauer Charles Zeiler. Sr. Helen John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Haven, 20714 Jacqueline Benjamin, Daughter Alder Place, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08-13-2011 Baltimore, MD Most Holy Redeemer 21. Signature of neral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 100 20736 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw set and Death Immediate Cause (Final QU. **Physician** TAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Disé to for as a nonsequence off cause. Enter Underlying Cause (Disease or linjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day 5 Other (specify) Year Pregnant at time of death signed by the at d be detached fo 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed 21 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No ပ္ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Detrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 dew 33. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GENEULEUE LIGHTFOOT-TAYLOR, 445 HWY, ANNAPOLIS, M.D. 21431 15+

DHMH 17 Rev 7/2009

State Registrar 32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of M. State Registrar		artment of Hea <i>rtificate of Dea</i>			ene g. Ng 2011	28553
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	hatuari			2. Date of Death Month Augus 1		3. Time of Death 12:20рм
	Medic Examin		William Zuc  4a. Facility Name (if not institution, give street and number)	REUNAN	4b. City, Town, or Loca	ation of Death	Augusi	4c. County of Deatl	
ار			5101 River Road, #703  5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)		hesda <sub>Jnder 24 Hrs.</sub>	8. Date of Birth		tgomery hplace (State or Foreign
	Funeral Director		243-48-0343 1 🗷 M 2 🗆 F	79 Yrs.		ours Min.	April 23		h Carolina
	and show at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation	-			10d. Inside City Limits
	Maryla 28a-f	Director	Maryland Montgomery			hesda			1 🗌 Yes 2 ሺ No
	with the 23a or st be r	Funeral D	10e. Street and Number 5101 River Road, #703		10f. Zip Code	0816	10	og. Citizen of What Co U . S	untry? <b>S.A.</b>
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispan If Yes, specify Cuban, Me			14. Race - Amer Black, White	
21215-0036	ırs after ural", o I Exam	ted by	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 1 ☐ Yes 2 🕅 1 ☐ Yes 3 ☐ Yes	No	1 ☐ Yes 2 🗖 No Sp	pecify:		Specify: Co	ucasian
15-(	72 hou in "nati Medica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during OO NOT use retired)		ing	16b. Kind of Business	Industry
212	d within ygjene. her tha it, the l	Be Col	Elementary/Seconday (0-12) College (1-4 or 5	i+)	Attorne	<del>-</del>		U.S. Gove	inment
Maryland	be filed ental H rked ot ic even	To B	17. Father's Name (First, Middle, Last)  Isaac Louis Z	uckerman	18.	Mother's Nam	e (First, Middle, Mi Rebecca	aiden Surname) Zuckerman	
/ary	should and M is mai raumat	ir	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and N				
re, N	1 and 2 f Health item 27 other t		Sandra Zuckerman - Spouse 20a. Method of Disposition	20b. Place of Dispo	River Road,			20c. Location - City or	
Baltimore,	Page ment o tant: If jury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Judean Me	matory or other place) Emorial Grdn	ıs 08/2	1/2011	Olney, Ma	ryland
Ball	permit Depart Impor any in	r	21. Signature of Funeral Service Licensee  W015		2. Name and Address of				Home, Inc. ng, MD 20904
Ť.			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ent					Approximate Interval Between
	Medical		regulting in death)	tatic Rena	el Cell Carc	inoma			Onset and Death
Ų.	Examiner	<u>.</u>	Suggest flathy flat our afficing						
_	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a consequence of):					
	e execu	al Ex	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
1760	icate be g physic is the b	<b>l</b> edical	d						
89 x	th certif ttending or use a	Physician/M		2 Fetal death 3				23d. Date of de Month	livery Day Year
). Bo	the dea by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	at time of death 5 l	Other (specify)			Nontr	Duy 10th
Division of Vital Records, P.O. Box 68	es that i	þ	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause given ir	n Part I.		acco use contribute to	the cause of death?
ords	v requir s been s should	Completed					24a. Was an	24b. Were au	topsy findings available
Rec	The lav ate has page 2	Comp					autops perforn 1 🗌 Yes 2		completion of cause of
ital	sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 X No Hospital: 1 Insertice.	ient 2 🗆 ER/Outpatie	Other	of Death (Chec		a∏ 011 / (2)	26.4
of	ng Phy fter this ineral d	ate: To	27. Manner of Death  1 X Natural 5 □ Pending (Month, Da)	iry 28b. Time o			28d. Describe ho	nce 6 Other (Spec w injury occurred	<u> </u>
sion	Attendi r death. ctor: A by the fu	Certificate:	2 Accident Investigation	ury - At home, farm, st		2 🗆 No	28f. Location (Str	eet and Number or Ru	ral Route Number,
<u>&gt;</u>	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the buriat cansil		building, etc				City or Town,	State)	
	ie Hosp n 24 hor ie Fune bleted fi	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e	examination and/or invest	stigation, in my opinion, de	eath occurred a	it the time, date and	d place, and due to the	cause(s) and manner stated.
_	With a book		29b. Signature and title of certifier		29c. License nun			9d. Date signed (Mont	
	, ,		30. Name and address of person who completed cause of d			22775		August 19,	2011
			Frederick Barr, M.D., 5454	Wisconsin		300, C	hevy Cha	se, Maryla	nd 20815
	Stat Registra		31. Date filed (Mooth Day, Year) 82. Registro	ar's Signature	4.1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G924, 2/14/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Vassilia Catherine Agoris 201 Sentember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospital Center Westminster 9. Birthplace (State or Foreign Country) L/V/ 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 ⋤ F WV 85 Yrs **Director** April 8 1926 Usual Residence of Deceden ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County Director MD Carrol1 New Windsor 1 Yes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 3120 Buffalo Road 21776 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) VISUAL Elementary/Seconday (0-12) College (1-4 or 5+) ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Calliape Atlas Theodore Batlas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3120 Buffalo Rd., New Windsor, MD 21776 Mr. Richard Agoris (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State New Oakland Cemetery 9-7-11 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight Herbert Box 195 Sykesville, MD 21784 .0. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 100 Medical Due to (or as a consequence of): Examiner 1000 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ea 3 Probably 4 Unknown 1 🗌 Yes No certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed. 2 No 1 Yes 2 No To the Funeral Director. After this certification and letter filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Mannier of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 29d. Date signed (Month, 29b. Signaturg Name and address of person who completed cause of death (Item 23a) (Type, Print) am Date filed (Month Day, Year) ajstrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28555 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 06 2011 Marjorie Kathleen Arno1d 10:24 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3811 St. Barnabas Road apt.#101 Prince George's Suitland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🗓 Min Hours 04/01/1942 Maryland **Director** 213-38-3963 69 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD Prince George's Suitland ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3811 St. Barnabas Road apt.#101 20746 USA items death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. 9 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Black. Health and Mental Hygiene. tem 27 is marked other than "natural", Completed 3 Divorced 4 X Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) vears Nurse Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Richard Brown Erna Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau Marlon Brown/Son 1856 Continental Ave., Las Vegas, NV 89156 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 9/12/2011 4 Donation 5 Other (Specify) Brentwood, MD 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service License 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sloned by the attendion abusined. burial-transi resulting in death) Last attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prednant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 Yes 2 No To the Funeral Director; After this certific: completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital. Other: 2 XNo Certificate: To 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature

Registrar

DHMH 17 Rev 7/2009

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 28556 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 1125 AM Anna Marie Brown 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Park Baltimore n/a Social Security Number Birthplace (State or Foreign Country)

MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 T Hours Min Days 1-5-1934 220-30-7001 77 Director Yrs. Usual Residence of Deceden 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i Funeral 3621 Cottage Avenue 21215 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Nurse Spring Grove Hospital Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ John Randall Dora Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Rice/Son <u>6718 Dogwood Road, Gwynn Oak, MD 21207</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-8-2011 KIng Memorial Park Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A of Balto. Co. Signature of Funeral Service Vicenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i i n disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Arrest 20 minutes ardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Due to (or as a consequence of) Exami executed Aspiration neumonit attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law equires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown een Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perforn rmed? After this certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD AT2438946-DIO 8/31 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University Parkway, Baltimore MD 21218 201 E. D La

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

SEP 0 8 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 20 Medical 4a. Eacility Name (if not institution give street and number) City, Town, or Location of Death Examiner 4c. County of Death -mure Medical LtimoRe Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD M 2 □ F Director Usual Residence of Deceden fshow and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County City, Town or Location 10d. Inside CityLimits Director 1 Yes 2 No imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11. Marital Status 12. Was Decedent Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced Completed Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Be Father's Name (First, Middle Department of Health a Important: If item 27 is any injury or other trau of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Umo Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year been signed by the should be detached g Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performe Yes 2 No 2 🗆 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Tes Other: ဂ္ 2 No 1 Inpatient ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury s after death. I Director: After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5  $\square$  Pending work? 1 🔲 Yes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 28558 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Kenneth Ray Beaver 11:23A a 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Coste
5. Social Security Number 6. Sex 7. Age (In yrs. last bil Baltimore Baltimore, MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 34 6072 Director 256 06 2,17,1976 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No GA Union Blairsville 10e Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 58 Beaver View 30512 U.S.A. items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, " Hygiene. other than "natural", or iter vent, the Medical Examiner Armed Forces? Black, White, etc. 1X Never Married 2 ☐ Married 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A 12 Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F and and by Jf Health and Jf Heal ပ္ Shirley Wishon Hubert Beaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 58 Beaver View, Blairsville, GA 30514 Shirley Beaver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation ☐ Other (Specify) Zion Hill Cemetery 9-11-11 Blairsville, GA 22. Name and Address of Facility Mountain View Funeral Home P.O. 1676 Blairsville, GA 30514 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Subaradmoid 9/3/11 - 9/5/11 hemmorhage disease or condition Medical resulting in death) Examiner presumed Meningitis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the desired exerts) Exami burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **P**  Hospital or Attending Physician: The law requires t
 Hours after death.
 Funeral Director, After this certificate has been sign Division of Vital Records, Post heart transplant + liver transplant on immunosuppressive 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an therapy. autopsy page 2 1 🗌 Yes 2 🔀 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 09,05,2011 Romy Bricker MD 1659670891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

St.

Balkmore, MO

21201

22 S. Greene

Bricker

SEP 0 8 2011

31. Date filed (Month, Day,

11-06657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

orris Burgess		1- For State Registrar	State	of Maryland		rtment of		nd Men	ıtal Hy	_	20		28559
Physic		1. Decedent's Name (First,	. ,							2. Date of Dea Month	eg. No.	$\neg \neg$	3. Time of Death
ledical Exam	iner	Morris McCall- 4a. Facility Name (if not ins				- L	4b. City, Town,	or Location	of Death	Septembe	er 3, 2011		1827 hrs
		Howard County G					Columbia		OI Death		Howard	Death	
Funeral		5. Social Security Number	6. Sex		e (In yrs. Ia	st birthday)	If Under 1 Y		er 24Hrs.	8. Date of Bi	th(MM/DD/YYYY)	9. 8 irth Foreign	
Director	1	218-60-8125		M 2 F		56 Yrs		ays Hours	s Min.	4-7-19	55	Cou	intry) MD
¥103		Usual Residence of Deceder 10a. State 10b. Co			10c. City,	Town or Locati	ion		_	10000			10d. Inside City Limits
and show :	<u>_</u>	PA Yo	ork		Sta	netator e							1 Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number			DLEN	<u>artstowr</u>	10f. Zip Code			1	0g. Citizen of Wha	at Coun	try?
th the ] 23a or	Ö	7 Aspen Court					173				USA		
ath wi items	Funeral	11. Marital Status 1 Never Married 2		12. Was Decedent Armed Forces?		6. 13. Wa	s Decedent of I es, specify Cub	Hispanic Original Jan, Mexican	gin? ( Spe ı, Puerto F	cify Yes or No Rican, etc.)	- 14. Race - White,		can Indian, 8lack,
ifter de d", or	by Fu	3 Widowed 4		If Yes, Give Year	X No	1	Yes 2 1	No specify:			Specify: A	\fric	an-American
hours a		15. Decedent's Education				16a. Deceden	t's Usual Occup ost of working I	pation (Give	kind of wo	ork done	16b. Kind of 8us		
0036 within 72 hou iene.	plet	Elementary/Secondary (0	)-12)	College (1-4 or 5	5+)		_			iu)	D A.	. <b>.</b> . C	-1
5-00 led with Hygiene other t	Completed	17. Father's Name (First, M	iddle, Last)			DISI	ness Mgm			First, Middle, I	Papa Au Maiden Surname)	100 5	ates
21215-003 ould be filed within I Mental Hygiene. I marked other the	Be	James Burgess						Hen	rietta	a Sands			
MD 21215-0036  42 should be filed within 72 hours after death with the Maryland tilth and Montal Hygiene no 77 is marked other than "natural", or items 23a or 28a-f she umatic event, the Medical Examiner must be notified at once	To	19a. Informant's Name/Relationship (Type, Print )  Jovi Burgess/ Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 8529 Black Star Circle, Columbia, MD 21045										, State,	Zip Code)
그 경험 문문		20a. Method of Disposition			20b. PI	lace of Disposi	ition (Name of			Date Page	20c. Location - (	City or T	own, State
Baltimore, permit. Pages 1 an Department of He important: If ite		1 8urial 2 X Crem 4 Donation 5 Oth		Removal from Sta		ematory or other			9 <b>-1</b> 2-	-2011	Baltimore	s MD	)
Salti ermit. epartm nports		ign itere uneral	ice License	9e		22. N	ame and Addre		Whie	Pureral	Hote F.A.	ol	Saltimote Co.
		3a Part   Enter the disease	Ar complie	actions that are used	the death !						MD 21133		
Physician /Medical		23a. Part I. Enter the diseas failure. List only one	al se on each	h line.							est, shock, or hear	t	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final dis or condition resulting in dea	41.1	1coho1 ar			могрил	ie) Inc	OXIC	ation		$\dashv$	——————
	اة	Sequentially list conditions, if any, leading to immediate	b	ue to (or as a conse	auonoo ofti							_	
	Examiner	cause. Enter Underlying Ca (Disease or injury that initial	ause ted c										
xecuted 1 and - transit		events resulting in death) L	ast Du	ue to (or as a conse	quence of):								
iO, e be executed ysician and burial - transit	edical	X UNPENDED		AMENDED 23a,	27,28	Ba-f,pe	r me,g	119 9-	19–1	lsm			
3760 ificate I g phys s the bu													
Box 6876 e death certificate the attending phy ed for use as the I	lcia	past 12 months?		4 Pregnant et t	ime of deat	<u> = </u>	al death 3 ner (S <i>pecify)</i>	Ectobic	pregnano	су	Month	Da	ay Year
P.O. Box 6876 that the death certificat ned by the attending phy detached for use as the	Physician/M	1 Yes 2 No 9 Part II. Other significant co	Unknown	9 Unknown	hut not soo	udian in the		al and to D		OO Distri			
i, P.O.	á	The state of the s	inaraone C	ontroduing to death	but not res	atting in the u	idenying cause	given in Pa	ITT I.				ne cause of death?
cords, aw requir	Completed						· -			24a. Was a			ppsy findings available
teco The law ate has	E O									autop perfor	med? de	or to co ath? Yes	mpletion of cause of
Vital Rec yrician: The his certificate director, page	B B	25. Was case referred to me examiner?					26.Pla	ce of Death (	(Check on			7 163	
Physical direction	2	1 Yes 2 No 27. Manner of Death	Hos	spital: 1 Inpatier		R/Outpatient						Other:	
on of anding Phath.	ξį	1 Natural	Pending	28a. Date of Injur (Month, Day,Ye	ar)	28b. Time of In		uryatWork' Yes 2. ★	1	8a. Describe r I <b>nknown</b>	now injury occurred	į	
Division of Vital Records, tal or Attending Physician: The law require 1s after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	ifical		Investigation Could not be	28e Place of Inju		d 1:00 ne, farm, street	аш					or Rura	al Route Number, City am Cir. #201
Divi Bospital or 7 24 hours after Funeral Dire	Certification:	4 Homicide	determined	(Specify)	Apart	ment				or Town, Si Columbi	tate) 5816 Wy a, Md.	ndh	am Cir. #201
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physonompietely filled in by the funeral director, page 2 should be detached for use as the b	edica	one) 2 Medical	Examiner: 0	: To the best of my on the basis of exam nd manner stated.	knowledge ination and	, death occum	ed at the time, on, in my opinio	date and pla on, death occ	ice, and di curred at t	ue to the cause he time, date a	e(s) and manner a and place, and due	s stated e to the	I. cause(s)
	Σ	29b. Signature and title of ce	ertifier	,	11	1		ise number			29d. Date signed		
	-	30. Name and address of pe	rson who ac-	mpleted source of	2th /!ta== 2	1 4	0.0	.M.E. ———			September 6	ک, 201 	1
		Zabiullah Ali, M.D.	Assista	ant Medical Exa	aminer	900 W. Ba	altimore Str	eet, Baltir	more, M	1D 21223			
St Regist		31. Date filed (Month, Day, Ye		32. Registrar	s Signature	best							
0HMH 17 Rev 1/20 0CME 2006	001			June 1	-	ORIGINAL			_			OGM	-
IFIL 2000													

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

harles Bryant	State of Maryland / Department of Heat 1-For State Certificate of Deat		ne 2011	28560
Physician Medical Examine		Mo	te of Death onth Day Year ptember 1, 2011	3. Time of Death 0936 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City	r, Town, or Location of Death	4c. County of Deat	h
Funeral Director		nder 1 Year If Under 24Hrs. 8. D	Date of Birth (MM/DD/YYYY) 9. Bit Forei	
id bow any cc.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 X Yes 2 No
nor 28a-f show	10e. Street and Number 10f. z 1017 Turpin Lane 2	Zip Code 21202	10g. Citizen of What Cou	untry?
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Martelal Hygiers, the Health and Martelal Hygiers, the Wasturalt, or items 33s or 28s-f sho other traumatic event, the Medical Examiner must be notified at once. To Re Commission the Firmeral Director	11. Marital Status  1 X Never Married  2 Married  3 Widowed  4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 X Yes  2 No  1f Yes, Give Year  1 9 7 8  1 Yes	dent of Hispanic Origin? (Specify \) cify Cuban, Mexican, Puerto Rican, 2 X No specify: al Occupation (Give kind of work do	, etc.) White, etc. Africa Specify: Am	er.
5-0036 ed within 72 hour. lygiene. other than "natu the Medical Exan	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) 1  Soldi	vorking life. DO NOT use retired)	U.S.Arm	•
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica	John Bryant	Jean Ross		
MD 21 d 2 should lith and Me m 27 is ma numatic ev	Tanika Bryant/Daughter 5312 Go	ss (Street and Number or Rural Roodnow Rd, Apt.	I,Balt.,MD 2	1206
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygient Important: If tiem 27 is marked other injury or other traumatic event, the Me To Re Com	20a. Method of Disposition 1	erest V 9/12/	11 Owings M Baltimore	<del>ills,</del>
Balt permit. Depart Import injury	21. Signature of Funeral Tervice Licensee 5126	Belair Rd,Bal	P. Close F.S t., MD 21206-	5105
Physician Wedical Examiner	23a. Part Enter the disease or complications that caused the death. Do not enter the mode failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (Methadone) Intox Due to (or as a consequence of):		28-1-1-26	Approximate Interval Between Onset and Death
ă	Sequentially list conditions.			
scuted and transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
be exe sician surial -	d.	e,g920 10-7-11 s		
X 6876  ath certificate attending phy or use as the the sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1		23d. Date of deliver	ry Day Year
s, P.O. Bc ires that the dec signed by the a 1 be detached for			3e. Did tobacco use contribute to	
Division of Vital Records, P.O. Ial or Attending Physician: The law requires that it as after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaclering the funeral director.				utopsy findings available completion of cause of
fital Recsident The Sicient The Sis certificate Sirector, page	25. Was case referred to medical examiner?	26.Place of Death (Check only or DOA Other Nursing Hom	ne) ne 5 Residence 6 Othe	er:
n of Viding Physical After this funeral directory	27 Manner of Death 28a Date of Injury 28h Time of Injury	28c. Injury at Work? 28d. I	Describe how injury occurred	
Division o spital or Attending nours after death.  neral Director: After filled in by the function:	Accident  Accident  Accident  Suicide  Accident  Could not be determined  Accident  Ac	ory, office building, etc. 28f. L.	ocation (Street and Number or R r Town, State) 1220 Turp Ltimore, Md.	ural Route Number, City oin Ln.
Divis To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at to one)  2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	he time, date and place, and due to	the cause(s) and manner as sta	
J. S.		9c. License number O.C.M.E.	29d. Date signed (Mo September 2, 20	
	30. Name and address of person who completed cause deceath (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 900 V	V. Baltimore Street, Baltim	ore, MD 21223	
State Registra	31. Date filed (Month, Day, Year) 32 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4, 2011 Physician/ 8:20 P M Bauer Anne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 14,1940 Maryland 213-40-2092 Director 1 🗆 M 2 💢 F 71 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director 1 ☐ Yes 2 😾 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Roxleigh Road 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Crossing Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Alice Melvin Campbell Cunningham Irene should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1006 Roxleigh Road Towson, Maryland Edward A. Bauer Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. John's Church Cem. 9-9-2011 Hydes Maryland 4 Donation 5 Other (Specify) Lure of Funeral Selvice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road ass 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ arres diac disease or condition resulting in death) CIT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate if any leading to immedicause. Enter Underlying use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Separate at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) signed by the all be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 lammatory breast 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No heart disease 24a, Was an autopsy performed? Yes 2 No has certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No မ 1 Inpatient 2 R/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 York Rd, Suite 224, Tou 21204 Towson,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month

0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Pokmber 0810am 201 City, Town, or Location of Death **Examiner** timore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** 1 M 2 D F Director 6 : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 05 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College ( econdary (0-12) -4 or 5+ Johns Be 17. Father's Name (First, Middle, Last) ပ္ omas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ruoute Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License MD 16 Approximate Interval Between Onset and Death Ph. sician/ Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ☐ Pregnant at time of death
☐ Unknown ξ Month Dav Year signed by the at id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s performed 1 Yes 2 No 1 Yes 25. Was case referred to medica Be examiner? Impurent -Hospice Wit Hospital Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one 20 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28563 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Samuel W. Brown, Sr. Month 09 2011 4:10 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 212-32-6189 1**x** M 2 □ F Days Min Month, Day Year b 9, 1934 Months 77 Director MD Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil Perryville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 731 Concord Point Drive 21901 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Floyd J. Brown, Sr. Dorothy Cordell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 731 Concord Point Dr.; Perryville, MD 21901 Paul W. Brown/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 09-09-2011 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee Tul 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear hailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ PARKINSON'S DISEASE ) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 29c. License number 20

State Registrar

p.m.

3:50

JACKIE

31. Date filed (Month, Day, Year)

JONES.

SEP 0 8 2011

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:00P M Physician/ Mary A Bauer 2011 Sept Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Carroll Westminster 3952 Old Hanover Rd. 8. Date of Birth (Month, Day, Year) 5 – 24 – 1929 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Min. Days Hours 1 □ M 2 🔀 F MD 82 218-26-8155 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner machine. 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 X No Westminster MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 3952 Old Hanover Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Black, White, etc. Armed Force 1 Never Married 2 Married Yes 2 No þ 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Housewife 12 Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Nellie McDonough မှ Henry Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3952 Old Hanover Rd., Westminster, MD Irvin R. Bauer-husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State rimonium, MD 9-9-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFletcher Funeral Home 21. Signate of Funeral Service Licensee 254 E. Main St., Westminster, MD 21157 walten homos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23d. Date of delivery for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year Month Dav in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' T Vac Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ၉ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certificate: 1 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ap

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

700A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) 3. Time of Death Physician/ Month Day August 30, 2011 0100 hrs Medical Examiner Nathan Thao Lane Cool 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Foreign Country) Maryland Director 11/09/1982 214 02 1195 1 X M 28 2 F Usual Residence of Decedent 10d. Inside City Limits 10b Count 10c. City. Town or Location Glen Burnie 1 Yes 2 X No Anne Arundel Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21061 93 Mary Lane Apt. 101 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes White 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: <u>ځ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dry Wall 12th Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alan Wayne Cool Sr. Nancy J. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Hall / Mother 93 Mary Lane Apt. 101 Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 09/06/2011 Baltimore, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21225 Physician Approximate Interval Between Onset and /Medical aMethadone and Diazepam Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine rause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g919 9-9-11 sm X UNPENDED e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached for Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes page ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Japitar - 4 hours after dear. - ad Director: After the ft Natural Natural Unknown 1 Yes 2 X No Pending fd 11:00 pm fd 8-29-11 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) 3221 Halethorpe, Md. Bero Rd. determined (Specify) Found at residence Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 30, 2011 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Richard Francis Cioffi 2:30 P M Septembe: 2011Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Arden Courts Pikesville Baltimore Pikesville 5. Social Security Number If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Country)
New York Months Days Hours Min M M 2 I F Vrs Director 096-32-1080 70 1941 Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland notified at 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 4423 Keenan Drive 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 9 ģ 1 ★ Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 😾 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Cioffi other traumatic Leonora Messina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Monica Cioffi/wife 4423 Keenan Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 9/7/2011 Ardent Cremation Svc. Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc R uanita 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Fronto Tempora 19915 disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 iding p IF FEMALE: nse 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No q 🗆 Unknown g Unknown P.O. I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 page 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) director Hospital Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Assisted Living 2 No 1 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 🗌 No all er death. filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completed filled Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Sept, 6, 2011 00061199

 $Q_{j}$ 

State

Registrar

st. Svik 4105, Tauson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 0 8 2011

701 V Charles

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of I		d Mental Hy	/giene	2011	285	67
	Physicia Medic		1. Decedent's Name (First, Middle, Last Edythe W. Cardon	st)					2. Date of D Month Septem		t, 20¶1	3. Time of 3:50	
ز	Examin	er	4a. Facility Name (if not institution, give 5614 Ogden Road 5. Social Security Number 6. S		e (In yrs. Ia	st birthday)	4b. City, Town, o Bethe	esda _	Hrs. 8. Date of B	rth	Montgom  9. Birl	ery	or Foreign
	Director			□ M 2 <b>½</b> F	97	Yrs.	Months Days	Hours N	Septemb	er 30	, 1913 Peni	nsylvan	ia
	faryland Ba-f show tified at	ector	10a. State 10b. County  Maryland Montgom	erv	10c. City	, Town or Loc	Bethese	la				10d. Inside Ci	ity Limits
	ith the N 23a or 2 it be no	Funeral Director	10e. Street and Number		1		10f. Zip Code 208	16			itizen of What Co	-	
030	be filed within 72 hours after death with the Maryland ental tygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	5614 Ogden Road  11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 If If Yes, Give Year or Dates.				ispanic Origin? In, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	L,	14. Race - Ame Black, White Specify: Wh	rican Indian, e, etc.	
9500-61212	vithin 72 hour jiene. er than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		5+)	(Give I life. Do	ent's Usual Occup ind of work done of NOT use retired) Artist		working		Kind of Business	,	
Maryland	d be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last)  Clinton Ellis Ru	tter					Name (First, Middle Sheef	, Maiden	Surname)		
Man	3 2 should alth and I 27 is main traumant		19a. Informant's Name/Relationship (7) Frances Card / D			1	_		Rural Route Numb				
Baltimore,	permit. Page 1 and 2 should be files Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic ever once.		20a. Method of Disposition  1  Burial 2 X Cremation 3 4 Donation 5 Other (Speci	Removal from State	Moñ	lace of Dispo emetery, cren	sition (Name of natory or other place y um, Inc.	e) Se	ptember 2011	20c. L	_ocation - City or	Town, State	nd
Baltii	permit. F Departm Importa any injui		21. Signature Anna Service Cent	see	1619				Funeral Hom venue, Be	_			
	Physician/	3 0	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused one cause on each line Cardion	9.	. Do not ente						Approximation Interval Bet 10 year	te tween
	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	isease					20 year	rs
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to or as  Hyperli	a conse u	ence of:						30 year	rs
200	ate be exec thysician an the burial-tr	dical	resulting in death) Last	Due to (or as Hyperte		,						30 year	rs
. Box 68/60	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	Ideath 3 □	Ectopic pregnand Other (specify)	су			23d. Date of de Month	-	Year
ν. Ο	res that th signed by if be detac	þ	Part II. Other significant conditions of Congestive hear	J	out not resu	ulting in the u	nderlying cause gi	ven in Part I.			use contribute to		
Kecords,	The law requi	Completed							24a. Wa aut per		24b. Were au prior to death?	topsy findings completion of completion	available
VItal	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			_ loth	er.	Check only one)				
N OT	nding Phy tth. : After this : funeral d	cate: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da	iry	ER/Outpatien 28b. Time of injury	28c. Injur	4 ∐ Nursii y at	ng Home 5 🔀 Res 28d. Describe			cify)	
DIVISION	al or Atter s after des Il Director ed in by the	l Certificate:	3 Suicide 6 Could not be 4 Homicide determined	oe Place of Inju	ury - At hor c. (Specify)	me, farm, stre	eet, factory, office		28f, Location City or To		nd Number or Ru e)	ral Route Numi	ber,
	he Hospitt in 24 hour he Funera pleted fille	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in my opini	on, death occur	red at the time, date	and plac	e, and due to the	cause(s) and ma	anner stated.
		_	19b. Signature and tiple of certifier	21 ful	wip		29c. Licens				ate signed (Mont tember 7		
	D		30. Name and address of person who Richard Rubin, M.					00, Che	evy Chase	, Ma	ryland	20815	
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 8 2	32. egisti	ar's Signati	ure	uli						
						-							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or I	Print in	Black	Indelible In	k. Ensure A	All Copie	s Are	Legible.		
		For		State of	Marylar		partment of		vlental Hy	_		00560	
		State Registrar				Ce	ertificate of	Death	T	Reg. N	2011	28568	
Physicia	n/	1. Decedent's Name		,					2. Date of De Month	Day	Year	3. Time of Death	
Medic	al	WILLIAI			LINE	<del></del>	T		Septem				
Examin	er	4a. Facility Name (if		ngton Med:	,	ntor	4b. City, Town, c	or Location of Death		4c. County of Death  Anne Arundel Co.			
Funeral		Social Security No.		. Sex 7	. Age (In yrs. i		) If Under 1 Year		8. Date of Bir				
Director		415-34-6	268	1 🕅 M 2 🗆 F	83	Yrs.	Months Days	Hours Min.	10/04/	y, Year) Country) /1927 Georgia			
ld bow	ŗ.	Usual Residence of 10a. State	Decedent 10b. County		100 0	ty, Town or L	ocation					10d. Inside City Limits	
arylan a-fsh fied	cto	MD		Arundel Co		len Bu						1 Yes XX No	
or 28 noti	Ö	10e. Street and Nun			-		10f. Zip Code			10a. Citi	zen of What Cou		
with t	Funeral Director	1005 G	enine Di	cive				21060			United States		
items	Fun	11. Marital Status		12. Was Deced		S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No-		14. Race - Amer		
", or	by	1 Never Marri		1 Yes 2	es? 2 □ No 194 194	, ,	1  Yes 2 No		nican, etc.)		Black, White, etc.  Specify: White		
ours a	Completed	3 Widowed	4 ☐ Divorced	Year or Date	es.						- 11		
72 h in "na Medic			cify only highest	grade completed)		(Giv	edent's Usual Occu e <i>kind of work done</i> DO NOT use retired	during most of work	king	16b. Ki	nd of Business I	ndustry	
within giene. er the		Elementary/Seco 12 y:		College (1-4	or 5+)		Electrici			Ci	ty of Ba	altimore	
al Hyg d oth	Be	17. Father's Name (/		st)				18. Mother's Nam	ne (First, Middle,	Maiden S	Sumame)		
Ild be Ment arker atic e	2	William	Garfie	eld Cline	2			Kather	ine I	ay1o	r		
shou n and 7 is m raum		19a. Informant's Na				19b. Ma	iling Address (Street	and Number or Rur	al Route Numbe	er, City or	Town, State, Zip	Code)	
and 2 Healti em 2 ther t		Mrs. Mary 20a. Method of Disp		Cline / v		_	5 Genine		len Bur			060	
nt of nt of t: If it		1 🛚 Burial 2 l	☐ Cremation 3	Removal from S	tate (	cemetery, cr	oosition (Name of ematory or other pla	ce)	Date		cation - City or		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation  21. Signature of Fur	5 Other (Sp		Mea		dge Mem. 22. Name and Addre					Maryland	
permi Depar Impor any in		) 1K	0)0	2/	MO 1		ervices P						
		23a. Part 1. Enter the	he disease, or c	mplications that car y one cause on each	used the deat	h Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory ar			Approximate	
Physician/		Immediate Cause (i	Final	y one cause on each	1 lille.	NE	Pauce Pauce	A				Interval Between Onse and Death	
Medical		resulting in death)	4	Due to (or	as a conseq	uence of):		<u>.</u>	0-			1.10	
Examiner	౼	Sequentially list cor	nditions,	b. H	enl	e '	auc	redu	us			I Week	
sit sit	mine	if any, leading to im cause. Enter Under Cause (Disease or i	rlying 🌠	Due to (or	as a conseq	uence of):							
e executed cian and urial-transit	Examiner	that initiated events resulting in death) I	6	c. Due to (or	as a conseq	uence of):							
siciar buris	<u>a</u>												
eath certificate be attending physicii I for use as the bu	Physician/Medic	IF FEMALE:		-									
h cert tendir r use	an/I	23b. Was decedent in the past 12 r		23c. If yes, outco	me of pregna		Ectopic pregnan	CV			23d. Date of deli	,	
the at	/sici	1 Yes 2 S		4 ☐ Pregna 9 ☐ Unkno	nt at time of e		Other (specify)				Month	Day Year	
v requires that the de been signed by the should be detached			cant condition	s contributing to dea	th but not re	ulting in the	underlying cause gi	iven in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?	
ires the signer of the signer	Completed by	Chron	e a	strel	e f	ulr	umary	Dueon	1 🗆	Yes 2[	□No 3□Pr	obably 4 Unknown	
v requ	lete	Corone	ru A	tern	Dia	اموه	U		24a. Was	an	24b. Were aut	opsy findings available	
he lav te has age 2	ome		0							ormed?	death?	ompletion of cause of	
ian: T rtifica xtor, p	Be C	25. Was case referre	ed to medical				26. P	lace of Death (Chec	1 ∐ Yes k only one)	2 No	I LI Yes	2 L No	
hysic his ce Il direc	To E	1 🗆 Yes 2 🗓	J/10	Hospital:	patient 2	ER/Outpati	ent 3 DOA Oth	ner: 4  Nursing He	ome 5 🗆 Resi	dence 6	Other (Speci	fy)	
ding Physician: The law h. After this certificate has funeral director, page 2	ate:	27. Manner of Death	n 5 ☐ Pending	28a. Date of (Month,	injury Day, Year)	28b. Time injury	wor	k?	28d. Describe	now injury	occurred		
ttend death stor: / / the f	Certificate:	2 ☐ Accident 3 ☐ Suicide	Investiga 6  Could no	t be	Inium. At he	man farma a		Yes 2 No	005 1	24		15 11	
il or Attendin safter death. I Director: Aft d in by the fur		4 🗌 Homicide	determin		, etc. (Specif)		treet, factory, office		City or Tov		Number or Hun	al Route Number,	
ospita hours ineral d fillec	Medical	29a. Certifier 1	Certifying P	hysician: To the bes	t of my know	ledge, death	occured at the time	e, date and place, ar	nd due to the ca	use(s) and	d manner as stat	ted.	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director, page 2 should be detached for use as the but the but the funeral director.	Med	(Check 2		miner: On the basis urse Practioner: To	of examinatio	n and/or inve	estigation, in my opini	ion, death occurred a	t the time, date a	and place,	and due to the c	ause(s) and manner stated	
Nith Co		29b. Signature and	tile of certifier	M AH	-	0	29c. Licens	e number	00		e signed (Month,		
111			mae		udy		octor	D216	04	0	7-06	-2011	
X		30. Name and addre	ess of person wh	o completed cause	of death (Item	T229) (Type,	CHIL H	MY DA	CANDI	1/A	MD	-2011 21122	
Stat	e	31. Date filed (Month)	TICL HC	32 Fee	Istrar's Signa	tura	C 12 W	-21/11/	21100	V( )	1.00	XIIAU	
Registra		S	EP 08	2011	wa ,	B. A	arkel						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28569 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 5, Physician/ Elbert Edwin 4:20P M Denhard, Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Mapels of Towson Towson Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Director 212-20-4796 91 1X M 2 F 6/4/1920 Maryland 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2XXNo Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Harnel Court U.S.A. 21013 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: Hygiene. If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Research Engineer Engineering 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Elbert Edwin Denhard, Sr. Katherine Brine Lerp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Ann Rinn / Daughter 1200 Mapel Leaf Court Hunt Valley, Maryland 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/9/2011 Joseph Ch. Cem. Cockeysville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ,∤h,si∟ian disease or condition resulting in death) CINCO Medical Due to (or as a consequence of) Examiner MKINOWN 5 V Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and -tran: that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Box 68760 attending ph 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day been signed by the should be detached 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 DN 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Special Control of the Contr 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending of the transport of transport of the transport of trans Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who campleted cause of death (Item 23a) (Type, Print) . Dr. suite 30. Name and ad Franklin Sq Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Physician/ Katherine DIVER September 5:20 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlestown Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct. 24 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 M 2 DE Min. 437-24-4341 93 Mary land Director Yrs. 1917 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 719 Maiden Choice Lane, Apt. BR 607 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 t à 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Completed 3 ▼ Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene, Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Franklin Jackson Mary Agnes Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George J. Diver-son 5817 Meadowood Road, Baltimore, MD Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Oak Lawn Cemetery 4 Donation 5 Other (Specify) 9/8/11 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ond Stage Câ Cardiomye Dathy disease or condition resulting in death) a End Medical xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records.

Division of Vital

Catonsville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Choice

709 Maiden

R144682

9/6/11

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hallie R. Dreyer 3:40 P Medical September 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Encore at Turf Valley Ellicott City Howard 5. Social Security Number Date of (Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth Hours 1 🗆 M 🗶 🗆 F **Director** 212-07-2448 89 Jan Maryland Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Frederick Mt Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14564 Black Ankle Road 21771 United States "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death a popartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Assembly Line Worker Distillerv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Harrison Hallie Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Dreyer/son 4564 Black Ankle Road Mt Airy, Maryland 21771
e of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Ardent Cremation Svc 9/6/2011 4 Donation 5 Other (Specify) Hanover, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc uanta K 4112 Old Columbia Pike Ellicott City, MD 21043 Homas 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Physician/ Medical Onset and Death Dementia disease or condition resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Hospital or Attending Physician: The law requires that the death of 24 hours after death.
 Funeral Director: After this certificate has been signed by the atter Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna5 ☐ Other (specify) Pregnant at time of death Day Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2x No Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 ho

To the Fune

completed fi (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number M.D D47447 September 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 Cedar Lane Suite 103 Columbia, Maryland 21044 Andy Lazris. M.D 32. Registrar's Signature State SEP 0 8 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 September 5:20 PM George William Driskill Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Montgomery Rockville Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, July 27, 1 👿 M 2 🗆 F Months Hours Director 230-24-9065 88 Alabama Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 4 Day Road 20850 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces'

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married <sup>2 □ No</sup> 1943-Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced 1964 ed other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Non Commissioned Officer United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Robert Lee Driskill Fannie Mae McPhearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail M. Driskill/Niece 4 Dav Road, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Cemetery 21. Signature of Funeral Service Livensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 town Mari M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list our little as if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier ale Cular Dr. Rock Ville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16:43 PM Month 8 Day SO Physician/ JOSE PH EHART Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, **Examiner** N/A CENTER BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthdav) **Funeral** Hours 03725/1936 1 X M 2 🗆 F Maryland 75 219 32 8789 **Director** Usual Residence of Decedent 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 🗌 Yes 2 😾 No Baltimore Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or items 23a Funeral 21225 123 Cedar Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Fireman Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Catherine Kemper August Ehart traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Patricia Ehart / Wife 123 Cedar Hill Road Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/02/2011 Baltimore, Maryland Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Furieral Service Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST Physician/ disease or condition resulting in death) Medical **Examiner** MYUCARDIAL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying ORONARY Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART FAILURE, CHRONK 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No DIABETES MILLETUS TYPEZ 24a. Was an KIDNEY DISEASE autopsy performed? Yes 2 No HYPOTHYROIDISM 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined completed filled in by 24 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one 29b. Signatu Justin Skweres RESOO1 and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, STREET HANOVER parke State

DHMH 17 Rev 7/2009

Registrar

SEP 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:05 p Physician/ September 3, 2011 Iona Μ. Franke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Parkville Oak Crest Care Center Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 👽 Months May 28, Ye Marwland <sup>3</sup>√917 212-09-3002 94 **Director** Usual Residence of Decedent show 10a. State 10b. County with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Parkville Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. #218 21234 8830 Blvd. Walther permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatin excess. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ W. Krauss Iona Harry Η. Moulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7681 Woodland Circle Easton, Md. 21601 James N. Franke / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 9/9/2011 Baltimore, Maryland 4 Donation 5 Other (Specify, New Cathedral Cem. 21. Signature of Funor 22. Name and Address of Facility 1050 York Road Towson, Md. 21204 Ruck Towson Funeral Home. Inc. 23a, Part 1. Enter the disease shock, or heart failure. Li cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 to 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 Tyes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? ☐ Accident 2 🗆 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

PANE

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month A Physician 8'.05PM 2011 /Medical me (If not institution, give steet and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE acknu 8. Date of Birth (Month, Day, Year) 04-06-1934 . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Months Days Hours 1 Yrs. 095-26-2016 Director JAMAICA Usual Residence of Decedent 10a State 10b. County 10d Inside City Limits 10c. City, Town or Location r 28a-f show 1 Yes 2 No Completed by Funeral Director MD KOSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? en "natural", or items 23a or Mudical Examiner must be a USA 21237 FOROCREST 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ∐Yes 25 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then STATE OF NEW YORK Elementary/Secondary (0-12) Coilege (1-4or 5+) ag g CARPENTER 12 f Health and Mental Hygien Item 27 is marked other the other treumetic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be GRANT VIOLET BRACKENRINGE LINCOLN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6818 FOROCREST ROAD. ROSE DATE, MO. 21237 GRANT (WIFE) MURIEL 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Importent: If it any injury or once. 5 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9/9/11 GREENMOUNT CREMATURY BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signal of Funeral Service 22. Name and Address of Facility VAUGHN GREENE FINERAL SERVIS ROAD. BALTO, YORK MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician erevoyou disease or condition resulting in death) /Medical ue to (or as a cons quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of Box 68760. The lew requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ned by the a P.O. 1 ☐Yes 2 ☐ No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 8 2011

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sadi

1012

29c. License number

Rt Way

40054424

29d. Date signed (Month, Day, Year)

Luther Ville, MD 21093

		For State Registrar	Please	State of M		d / Depa		of H	ealth and	_		e 2011		578
Physicia Medi		1. Decedent's Nam Elizabet	ne (First, Middle, La. h Campbe 1	1 Grant				<u> </u>		2. Date of De	ath	B, 2011		of Death
Examir	ner		fnot institution, give own Care	e street and number) Center			4b. City, T Caton		Location of Death	1		c. County of Dea Baltimor		
Funeral Director		5. Social Security N 216-32-0			ge <i>(In yr</i> s. <i>I</i> as 104	st birthday) Yrs.	If Under Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 30	th y, Year 1 9	9. Bi	rthplace (Stat ountry) Ma	e or Foreign ryland
land show d at	ξ	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	ation							City Limits
the Mary or 28a-1	Director	MD 10e. Street and Nu	Baltimor	e	Cato	nsvill	10f. Zip	Code			10g. (	Citizen of What C		Yes 2 🔀 No
th with ms 23a must b	Funeral		en Choice	Lane RGS		lao v	212			if - Ves e- N-		S.A.		
0036 urs after dea ural", or itel	۾ ا	<ul><li>11. Marital Status</li><li>1 ☐ Never Marital</li><li>3 🛣 Widowed</li></ul>	ried 2  Married	12. Was Decedent Armed Forces?  1  Yes 2 If Yes, Give Year or Dates.		l I	Yas Decede Yes, specif	y Cuban	, Mexican, Puert	oecify Yes or No- o Rican, etc.)		14. Race - Am- Black, Whi Specify: wh	te, etc.	
21215-0036 within 72 hours after glene. Per than "natural", o	Completed	(Spe Elementary/Sec 12	15. Decedent's E ecify only highest gr conday (0-12)		5+)	life. D	ent's Usual gind of work NOT use i Make	done du retired)	tion uring most of wor	rking		Kind of Business	a Industry	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (	17. Father's Name	(First, Middle, Last)			поше	Make		18. Mother's Nar	me (First, Middle, Roop				
Mary d 2 should alth and N 127 is ma			ame/Relationship (7 G. Whitne	ype, Print) y/Daughte	r							or Town, State, Z		
Baltimore, permit. Page 1 and Department of Hea mportant: If item any injury or other ance.			position  Cremation 3  5  Other (Speci	Removal from State	, ce	ace of Dispo metery, cren don Pa	atory or oth	er place	09-	Date 10-2011		Location - City o		
Baltii permit. F Departm Importa any inju			reral Service Licen		Me	Fu 16	Name and neral 30 Ed	Address Hom mond	of Facility Store of Ca Son Ave	erling A tonsvill		on Schward inc.		
be executed Medical Examiner and Enrial-transit	Examiner		art failure. List only of (Final on on ditions, nmediate arlying in qui y is	b. Due to (or as	a conseque	ence of):	r the mode	of dying,	, such as cardiac	or respiratory ar	rest,		Approxir Interval I Onset ar	Between nd Death
Division of Vital Records, P.O. Box 68760  The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2  Fetal	death 3	Ectopic pr Other (spe		,			23d. Date of do Month	elivery Day	Year
Records, P.C. The law requires that rate has been signed to page 2 should be deti	Completed by P	Part II. <b>Other s</b> igni	ficant conditions o	ontributing to death I	out not resu	Iting in the u	nderlying ca	ause give	en in Part I.	1 🗆 24a. Was auto	Yes :	prior to	Probably utopsy finding	Unknown gs available
Upct	Be Co	25. Was case referr	red to medical					26. Plac	ce of Death (Che	1 🗆 Yes	2		es 2 No	
Division of Vital Recc Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	은		No th 5 ☐ Pending Investigatio	28a. Date of inju (Month, Da	iry 2	ER/Outpatien 28b. Time of injury		c. Injury a	4 Nursing F at	dome 5 Resident Resid		6 Other (Spe	cify)	
Division ital or Attendir its after death.	al Certificate:	3 Suicide 4 Homicide	6 Could not be determined	e 290 Place of ini	ury - At hon c. <i>(Specify)</i>	ne, farm, stre	et, factory,	office		28f. Location (3 City or Tox		and Number or Ri te)	ural Route Nu	mber,
the Hospi hin 24 hou the Funer upleted fill	Medical	(Check 2 only one) 3	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	examination.	and/or invest	igation, in m	y opinion ed at the	n, death occurred time, date and pla	at the time, date a	and place e cause	ce, and due to the e(s) and manner a	cause(s) and s stated.	manner stated.
Note To Com		29b. Signature and	title of certifier		M	<del>}</del>	29c.	License	number			ate signed (Mon		コマハ
161		30. Name and and	ress of person who	completed cause of o	death (Item 2			ر م	hoice		70	tone	illo	MD
Sta Registr		31. Date filed (Mont	A A AA4	32. Registr	ar's Signatu	par						- VI LOV	++14	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ 7:05 p Muriel Garnett September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Chesapeake Hospice House Linthicum Anne Arundel Social Security Number If Under 1 Year \_ If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 224-24-5193 **Director** 1 □ M 2√ F 96 ct. 19, 1914 Virginia Usual Residence of Decedent show "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Linthicum |Maryland| Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 U.S.A. 826 White Ave. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married Completed by within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: 3X Widowed 4 □ Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Department of Health and Menta. Important: If fine 27 is marked to any injury or other traumair once. ည Louisa Looney Grover Garnett Eakin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 826 White Ave. Linthicum, Maryland 21090 Pamela Hanna / Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Bemoval from State 4 Donation 5 Other (Specify) Encombment Dulaney Valley Mauso. 9/10/2011 Timonium, Maryland 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the chease, shock, or heart fullure. Us dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consection or on and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Spec 은 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director; After this etely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier соmpletely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 28580 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 8 Month 3 Time of Death  $12^{\text{Day}}$ Physician/ 201°I 7:14 P M George Ρ. Hill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital g. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ Months Days Hours Min 6/17/75 Year) Maryland Director 579-94-4118 36 Usual Residence of Decedent 28a-f show 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Yes 2 No Prince George's Forestville ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 20747 3711 Donnell Drive apt. #201 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc "natural", or ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Private Laborer 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donna Spiller George Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3464 Brinkley Rd., apt.#402 Temple Hills, Md 20748 Donna Hill/Mother injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 09/01/2011 Waldorf, MD 4 Donation 5 Other (Specify) Heritage Cemetery 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pheumocyeti Physician/ arinni disease or condition Medical resulting in death) 15 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Vear Pregnant at time of death 1 Yes 2 9 Unknown 2 No 4 ☐ Pregnant 9 ☐ Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by +Sp/ration noumonia Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?
Yes 2 1 No 2 X No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ျ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only of

Registrar DHMH 17 Rev 7/2009

State

29b. Sign

31. Date filed Wonth, Day, Year SEP 0 8 2011

Box 68760

completed cause of death (Item 23a) (Type, Print)

Year 2011 6:45 Α 4c. County of Death Baltimore Co. Birthplace (State or Foreign Country) 7,1928 Maryland 10d. Inside City Limits 1 ☐ Yes 2 🗓 No 10g. Citizen of What Country? United States 14. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) Catherine Rose Malczewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1937 Dineen Drive Dundalk, Maryland 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cept 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, State SEP 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28582 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 Physician/ Thelma Lee Heber 2011 September 8:15 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Hours 04/27/1916 Director 95 219-28-8606 Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits Ellicott City 1 Tes 2 No MD Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5154 Waterloo Road 21043 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Howard Co. School Sys. Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or one. မ Charles Luther Deavers Blanche Mary Jewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Frank J. Heber - son 5154 Waterloo Road Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. John's Lutheran 09/09/2011 Columbia, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ STROKE DAYS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or in jury that initiated events Examiner Due to (or as a consequence of): burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executivitin 24 hours after death.

To the Funeral Director, After this certificate has hear somed to the control of the control Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FFMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation/CARDiomy pathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 1 ☐ Yes 2 ☐ No completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work' Accident 1 Tes 2 No M Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

SEP 0 8 2011

6336 CEDAR LANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLACKFORD CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2, 2011 Evelyn Lucreta Harr 2:40 P Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville 5 Social Security Number Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** n yrs 85 Months 1 M 2 X Days Hours 205-16-2014 December 25, 1925 Pennsylvania **Director** Usual Residence of Decedent or 28a-f shov f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 20906 12109 Selfridge Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 😿 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Manager Hygier other t 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, id Mental I marked o ည Walter Caton Mabel Thomas and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Thomas E. Harr/Son 3 Harvard Court, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o once. Page 1 September 6, Parklawn Memorial Park 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ lockville, Inc. 300 West Montgomery Avenue lockville, Maryland 20850 21. Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Left Lung Collapse Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 X No Month Year Pregnant at time of death 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law this certificate has autopsy nerformed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice Inpatient examiner' 1 🗆 Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu C. Joseph, MD

SEP 0 8 2011

31. Date filed (Mortin, Day, Year)

D0060634

1160 Varnum Street, NW, #021, Washington, D.C.

29d. Date signed (Month, Day, Year)

Physician Medica Examine

**Funeral** Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ph, sician Medical Examiner

	Please	e Type or Prin					•		Legibl	e.
	for State Registrar	State of Ma	-	epartment of I Certificate of I		and M	1ental Hy	giene Reg. No.	011	28584
/	1. Decedent's Name (First, Middle, La	ist)					2. Date of De	ath	Vae	3. Time of Death
in/ cal	Sonia Marie Jackson						SEPTEM	BER Day	2 J	4:25P M
ner	- / / / / / /	OSPITAL			LTIMO	RE			County of De	
	216-76-5582	Sex 1 □ M 2 🛛 F	(In yrs. last birtho 48 Yr	Months Dave	If Under: Hours	24 Hrs. Min.	8. Date of Bir		9. [	Birthplace (State or Foreign Country) MD
=	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location	_					10d. Inside City Limits
Funeral Director	MD Baltim	ore	Gwynn O	ak						1 🗆 Yes 2 🗐 No
	10e. Street and Number			10f. Zip Code	_				en of What	Country?
nera	3008 Essex Road			2120	97				JSA 	
y Fu	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces?	er in U.S.	<ol> <li>Was Decedent of F If Yes, specify Cuba</li> </ol>	lispanic Orig an, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	1	<ol> <li>Race - Ar Black, Wi</li> </ol>	merican Indian, hite, etc.
q pe	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	°	1 ☐ Yes 2X No	Specify:			s	pecify: A	frican-American
plet	15. Decedent's I (Specify only highest g			ecedent's Usual Occup		of worki	na	16b. Kir	d of Busine	ss Industry
Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	) lii	e. DO NOT use retired) Therapy				Ch-	imes	
Be	17. Father's Name (First, Middle, Last)	,	WOLK	пътору	18. Mothe	er's Name	e (First, Middle,			
욘	Melvin L. Jackson						Covingto			
	19a. Informant's Name/Relationship (	Type, Print)	19b. N	failing Address (Street	and Numbe	r or Rura	l Route Numbe	er, City or 7	own, State,	Zip Code)
	Lizzie Barnes/Mother  20a. Method of Disposition			8 Essex Road,	Gwynn					
	1 Durial 2 X Cremation 3	Removal from State		Disposition (Name of crematory or other place	ce)	9 <b>-7-</b> 20	Oate <b>711</b>	i e	nore, M	or Town, State
	4 Donation 5 Other (Spec		TECTO G							of Baltimore Co.
	1 1 may 16 6	le/		9200 Liberty						L DETCHINE W.
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	nplications that caused to	he death. Do not							Approximate Interval Between
	Immediate Cause (Final disease or condition		MULTI	PLE MY	SLON	17				Onset and Death
	resulting in death)	Due to (or as a	consequence of):							
er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):							1
Examiner	Cause (Disease or iinjury		oonsequence on.							
	that initiated events resulting in death) Last	C. Due to (or as a c	consequence of):							-
dica		<b>d</b>								
/Me	IF FEMALE:	23c. If yes, outcome of	progranov							
cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at t	Fetal death	3  Ectopic pregnand 5 Other (specify)	су			2	3d. Date of Month	delivery Day Year
Physician/Medical	9 Unknown	9 🗌 Unknown		_						
by P	Part II. Other significant conditions	contributing to death but	not resulting in t	the underlying cause gi	ven in Part I					to the cause of death?
Completed by							1 🗆	Yes 2		Probably 4 Unknown
mp(m							24a. Was auto		24b. Were prior to death	autopsy findings available to completion of cause of
	25. Was case referred to medical						1 🗆 Yes	2 No	1 🗆	Yes 2 No
To Be	examiner?  1  Yes 2 No	Hospital:	t 2   FR/Outo	atient 3 DOA Oth	er:		ne 5 Resi	dence el	Othor /S-	nacify)
	27. Manner of Death	28a. Date of injury (Month, Day,	28b. Tim	ne of 28c. Injur	y at		me 5 $\square$ Resi 28d. Describe I			receity)
ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not lead	on he		M 1 🗆	Yes 2	No				
Medical Certificate:	4 Homicide determined		r - At home, farm (Specify)	, street, factory, office			28f. Location ( City or Tov		Number or i	Rural Route Number,
dical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	ysician: To the best of m	y knowledge, de	ath occured at the time	e, date and p	olace, and	d due to the ca	use(s) and	manner as	stated. ne cause(s) and manner stated.
\ ■	only one) 3 Certifying Nu	rse Practioner: To the be	est of my knowled	ge, death occurred at th	e time, date	and plac	e, and due to the	e cause(s)	and manner	as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

> State Registrar

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

SINAI

63430

HUSPITAL

29d. Date signed (Month, Day, Year)

SEPTEMBER 4 2011

BAUTMORE

2011 28585

		Registrar	C	ertificate	e of	Death				g. No.	3 3	20000
Physic Modical Exam		Decedent's Name (First, Middle,Last)	Gregory T.	Jeff	ery			- 1	. Date of Death Month August 23,	Day Year		Time of Death 1415 hrs
		4a. Facility Name (if not institution, give s 2920 Sollers Point Road	treet and number)		41	b. City, Town, or Dundalk	Location o	f Death		4c. County of Baltimore		у
Funeral Director			7. Age (In yrs	. last birthda	y) Yrs.	If Under 1 Year Months Days			8. Date of Birtl 07/31	/1946	Foreign	ace (State or Y) Maryland
and show any nce.	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo		y, Town or t Bal								d. Inside City Limits Yes 2 X No
with the Maryland ns 23a or 28a-f sho be notified at once.	I Director	10e. Street and Number 2920 Sollers Po	int Road			10f. Zip Code 212	22		10	g. Citizen of What	-	?
fter death I", or iter	by Fune	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1 X Yes 2 No. Yes, Give Year V1 E t.	Nam .	If Ye	Decedent of His is, specify Cuban Yes 2 X No	Mexican, specify:	Puerto Ri	can, etc.)	White,	etc. Whi	
51 3 🗖.	Completed	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	duri	ing mo	s Usual Occupati st of working life. ner / Owl	DO NOT			16b. Kind of Bus $Pool\ 1$		lishment
21215-0036 and be filed within 7 Mental Hygiene. marked other than	Be		not availab					Jean	n Barba	aiden Surname) ra Zebro		
ore, MD 2 ss 1 and 2 should of Health and M If item 27 is m	To	19a. Informant's Name/Relationship (Typ Jean Heppding /	Mother	15	04	Address (Street	l Str	eet	Balti	more, Ma	aryla	nd 21226
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If them 27 is injury or other traumatic		20a. Method of Disposition  1 Burial 2 Temation 3 4 Donation 5 Other Specify:  21. Signature of Funeral Service License	Removal from State	crematory ayview	or other	ion (Name of cener place) CEMATORY ame and Address		08/2	Gilleria III		ore,	Maryland
Ba Perm Depa Impo	9	Jecome From	uour.		40	01 Ritch	ie H	ighwa	y Bal	timore,	Mary!	, land 21225
Physician /Medical £xaminer			<sub>line.</sub> herosclerotic Cardío	vascular			such as ca	rdiac or re	espiratory arre	st, shock, or hea		Approximate Interval Between Onset and Death
		or condition resulting in death)  Du  Sequentially list conditions,  b.	e to (or as a consequence	of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence e to (or as a consequence									
executed an and al - transit		d								<u></u>		
8760, tificate be e ng physician as the burial	n/Medical		AMENDED  23c. If yes, outcome of pre	gnancy						23d. Date of c	lelivery	
P.O. Box 68760, that the death certificate be executed ted by the attending physician and detached for use as the burial - transit	Physician/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of c	2	7	al death 3 [ er (Specify)	Ectopic	pregnanc	у	Month	Day	Year
<b>P.O.</b> res that the signed by t	ā	Part II. Other significant conditions co	ontributing to death but not	resulting in	the un	derlying cause g	iven in Par	t I.		acco use contrib		cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Completed								24a. Was an autops perform 1 Yes 2	y pr n <u>ed</u> ? de		sy findings available pletion of cause of 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2	ER/Outpa	tient		of Death (			Residence 6	Other Sc	ena –
on of Virtending Physicath.  or: After this the funeral dir	ition: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time		jury 28c. Injury	y at Work?	28		ow injury occurre		one -
Divisi Hospital or Att 24 hours after de Funeral Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify)	home, farm,	street	, factory, office bu	uilding, etc	. 28	8f. Location (St or Town, Sta		r or Rural F	Route Number, City
Division  To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Examiner: O	: To the best of my knowle n the basis of examination nd manner stated.	-								ause(s)
	Ĭ	29h Stgnature and little of certifier	Weel Ing	50		29c. License				29d. Date signed August 24, 2		Day, Year)
1		30. Name and address of person who cor Victor Weedn MD JD Ass	npleted cause of death (Iter istant Medical Exam	iner 90		Baltimore St	reet, Ba	altim ore	, MD 2122	3		
S Regis		31. Date filed (Month, Day, Year)	32. Registrar's Signa	tur	basi	le l						

DHMH 17 Rev 1/2001

OCME

**ORIGINAL** 

			Amend #25, 27,  State amend item 2 Registrar	Type or Pri	nt in Bl	ack In	delible	Ink E	nsur	e All Copie	es Ar	e Legible	
			1 - For amend item 2 Registrar	8e per me	g919"9	( <b>_25</b> 2¶ Cen	tificate o	f Deat	iin an th	u ivieritai n	ygren Reg. N	2011	28586
	Physicia	an/	1. Decedent's Name (First, Middle, La							2. Date of E	Death	Day Year	3. Time of Death
~ .	Medi Examir	cal	4a. Facility Name (if not institution, giv	e street and number		<u>K</u>	4b. City, Tow			scote	mp	er 5 2	825 AM
	Exami	ICI	The Johns Ho		aspi-	tal	Ball only				4	tc. County of Dea	ith
	Funeral Director		5. Social Security Number 6.		e (In yrs. last I		If Under 1 Ye Months Da	ar If Ur	nder 24 l		Birth Day, Year	g. Bi	rthplace (State or Foreign ountry) ryland
		١.	Usual Residence of Decedent			!				1 06/01	/ 192	Ma.	TATALIO
	larylan 3a-f sh ified a	Funeral Director	10a. State 10b. County  Maryland N/A		10c. City, To	imore							10d. Inside City Limits 1 XYes 2 □ No
	a or 28 be not	١	10e. Street and Number			111010	10f. Zip Cod	le			10g. 0	Citizen of What C	
	th with ms 23 must	mer	218 S. Duncan St	,			212					nited Sta	ates
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mediral Examiner must be notified at ance.	<u>\$</u>	Never Married 2 ☐ Married     XWidowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		lf.	as Decedent of Yes, specify C	uban, Mex	xican, Pu	(Specify Yes or No erto Rican, etc.)	D-	14. Race - Am Black, Whi Specify: W	
15-0	72 hou matu ledi al	Completed	15. Decedent's (Specify only highest g		1	(Give ki	ent's Usual Oc ind of work do	ne durina i	most of v	vorking	16b.	Kind of Business	Industry
21215-0036	within giene. er thar , the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5		life. DC <b>Llomem</b>	NOT use retii <b>aker</b>	ed)			L	omestic	
Maryland	ild be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last)  Lorne Dowell							Name (First, Middl	e, Maidei	n Sumame)	
ary	hould I and Me s marl umati		19a. Informant's Name/Relationship (	Type, Print)	I <sub>1</sub>	9b. Mailing	Address (Str			Langley Rural Route Numi	ner. City o	or Town, State 7	in Code)
	and 2 stealth	9	CHarles Martin -	Son						lalk, Mar			
Baltimore,	age 1 aent of h		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	ceme	etery, crem	ition (Name of atory or other	olace)		Date		Location - City o	
altii	permit. P Departm Importal any injui	8	21. Signature of Funeral Service Locer		LICTA								Maryland
<u>—</u>	20 = # 9	- 3	PRIKA			40	1 S. C	webe leste	er st	neral Ho reet Bal	mes timo	ore. Mar	vland 21231
	h sician/		23a Part 1. Enter the disease, or on shock, or heart failure. Lts only Immediate Cause (Final							liac or respiratory	arrest,		Approximate Interval Between Onset and Death
9	Medical Examiner		disease or condition resulting in death)	a. Respiration								(M)	
		Jer	Sequentially list conditions,	b. Subd			nem	ato	m	C- JANU	YWU	EXMINER	
	executed an and ial-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	C	<u>'</u>				ya	THE REPROVED BY	MEDIC		
0		I — I	resulting in death) Last	Due to (or as a	consequenc	e of):		(	CERTIFIC	****			
68760	ficate be g physicias the bu	Medic		d									
. Box 68	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal de		Ectopic pregn Other (specify					23d. Date of de Month	elivery Day Year
P.O.	that the derined by the a	by Pl	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	g in the un	derlying cause	given in F	Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
rds,	requires the been signer should be	ted								_   10	Yes 2	2 No 3 □ F	Probably 4 Unknown
of Vital Records,	: The law re cate has be ; page 2 sh	Completed		-						per	s an opsy formed?	prior to death?	utopsy findings available completion of cause of
/ital	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	Hospital:			1/	Place of Dther:	Death (C	heck only one)			
of \	g Physer this er this eral di	te: To	27. Manner of Death	28a. Date of injur		. Time of	3 □ DOA   28c. Ir	4 ∟ jury at	Nursin	g Home 5 Res			cify)
ion	Attending or death. sctor: After by the fune	Certificate:	7 Natural 5 ☐ Pending 2 X Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be			injury 1 <b>k</b>	M 1	ork?	2 📉 No	subje	-	•	
	声		4 - Homicide determined	28e. Place of Injurbuilding, etc.	. (Specify) idewal	k							Duncan Stree
	n 24 hours are Funeral I	Medical	(Check 2 L Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination and	d/or investic	lation, in my or	inion deat	th occum	ed at the time date	and plac	re and due to the	cause(s) and manner stated
_	To the within 2 To the comple	_	29b. Signature and title of certifier					nse numb		piace, and due to		ate signed (Mont	
•	12 8h			MD			Res	- C	00	0	Sep	tempe	r 5,2011
	v 2		30. Name and address of person who	completed cause of de	eath (Item 23a	a) (Type, Pri	EST.	BAL	TIN	NORE M	D :	21287	
	Stat Registra	_	31. Date filed (Month, Day, Year) SEP 0 8 2011	32. Registral									

DHMH 17 Rev 7/2009

Ketana

10c. City, Town or Location

Summerfield

7. Age (In yrs. last birthday)

89

12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:

College (1-4or 5+)

naules

1 XM 2 ☐ F

Certificate of Death

4b. City, Town, or Location of Death

Randallstown If Under 1 Year | If Under 24 Hrs Months Days Hours Min.

10f. Zip Code

16a. Decedent's Usual Occupation

Manager

34491

1 ☐ Yes 2 X No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Anna

2. Date of Death

Month Soft-www

8. Date of Birth Month, Pay, Year) 2/15/1922

Not Known

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Usual Residence of Decedent

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Vasily Ketara

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

177-18-4279

10e. Street and Number

10a. State

Director

Funeral

2

Completed

Be

ပ

Florida

11. Marital Status

4a. Facility Name (If not institution, give street and number)

6. Sex

17030 Southeast 115th Terrace Road

Madagaa Lada Jan 12 Ca

15. Decedent's Education (Specify only highest grade completed)

Chapel Hill Nursing Home

10b. County

Marion

er er	Lymi C. Recara-Lem /ex-wi	re 17030 Southeast 115th	Terrace Road
item 2	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Lo
Page nent c int: if	1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		/2011 Tows
permit. Pages 1 and Dupartment of Healt Important: If item 2 amy Injury or other	21. Signature of Punerat Service Licensee	22. Name and Address of Facility Ruc 1050 York Road Tov	
. (2)	23a. Part 1. Enter the disease, or complications that caused	the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,
Physician	shock, or heart failure. List only one cause on each lin Immediate Cause (Final	1 1 1 1 1	van4
/Medical Examiner	disease or condition resulting in death)  a.  Due to (or as a	a consequence of):	103101
executed in and ial-transit	cause. Enter Underlying Cause (Disease or injury	a consequence of):	
icate be executed physician and the burial-transit dical Examir	triat initiated events C.	a consequence of):	
g phy as the	U.		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	
that the property of detaction of the property	Part II. Other significant conditions contributing to death but	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco u
quires	-		1 □ Yes 21
or Attending Physician: The law requires that the de after death.  Director: After this certificate has been signed by the lin by the funeral director, page 2 should be detached trification: To Be Completed by Physic			24a. Was an autopsy performed?
clan: sertifica setor, p	25. Was case referred to medical	26. Place of Dea	ath (Check only one)
ysic direc	examiner? 1 ☐ Yes 2 🔼 No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence
ath. r: After the funeral	27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	rv 28b. Time of 28c. Injury at	28d. Describe how injur
al or Atte	3 Suicide 6 Could not be determined 28e. Place of Inju	ury - At home, farm, street, factory, office c. (Specify)	28f. Location (Street an City or Town, State
To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.  Medical Certification: To	29a. Certifier 1 Certifying Physician: To the best of check only one) 2 Medical Examiner: On the basis of and manner sta	of my knowledge, death occurred at the time, date and place f examination and/or investigation, in my opinion, death occu ated.	e, and due to the cause(s arred at the time, date and
To th within To th comp	29b. Signature and title of certifier	29c. License number	29d. Da
		✓ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	3 50
DXIV	30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print) 835 Surth Ale Math	tine MD
State	31. Date filed (Month Day, Year) Registra	ar's Signature	

28587 3. Time of Death Vear 5,2011 2030 4c. County of Death Baltimore 9. Birthplace (State or Foreign Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 📉 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Car Dealer 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34491 oad Summerfield, FL Oc. Location - City or Town, State owson, Maryland Funeral Home, Inc. yland 21204 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year acco use contribute to the cause of death? 2 ♣No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No nce 6 Other (Specify) w injury occurred eet and Number or Rural Route Number, State) use(s) and manner as stated. ite and place, and due to the cause(s) d. Date signed (Month, Day, Year) 6,2011

DHMH 17 Rev 1/2001

State Registrar For State Registrar

Funer Direct

ician/ edica	_			John	J.	King,	Jr.		SEPT	Day 0.2	90//	17:10 M
ninei		4a. Facility Name (if not ins Union Memo					4b. City, Town, or	Location of Dea		4c. Count	y of Death	
al or	5	5. Social Security Number 213-12-8545	6. Sex	M 2 🗆 F	7. Age (In yrs. k	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	s. 8. Date of Birth		9. Birthpla	ace (State or Foreign
Director		Usual Residence of Decede 10a. State 10b. C		ore		y, Town or Loc	ation	Esse				d. Inside City Limits 1 ☐ Yes 2 🛣 N
ley o		10e. Street and Number 520 Hopki	ns Land	ding Dı	rive		10f. Zip Code	21221		10g. Citizen of	What Countri d Stat	•
Ì	à	11. Marital Status 1 ☐ Never Married 2  3 ☐ Widowed 4 ☐ Di	Married	2. Was Deced Armed Ford 1 X Yes If Yes, Give Year or Date	2 No	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ın, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ce - America ck, White, et	
Po Comple					1 or 5+)	(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired) ron Work	during most of w			Indus	
Ę	2	John King,	Jr.		-	19b. Mailin	a Address (Street	Ma	ame (First, Middle, I Ae Gatton  Rural Route Number	- 111		ode)
		Mrs. June W 20a. Method of Disposition 1 □ Burial 2★ Crer	. King	(Wife)	20b. F	Place of Dispos	Hopkins  ition (Name of atory or other place	1	Dr. Ess	ex, Mar		
once.		1 Burial 24 Crer 4 Donation 5 C	ther (Specify)	0	itale	1top S	ervice C	orp. 9/8 Funeral	3/2011 Home of andalk, Ma	Dunda1		
edical Examiner	Lyallille	23a. Part 1. Enter the disasshock, or hear failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	List only one	Due to (o		uenge of):  White uence of):	a long	Distri	ac or respiratory arm	idron		Approximate Interval Between Onset and Death
Physician/Madical		F FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	"	1 🔲 Live B	ant at time of o	aldeath 3 🗌	Ectopic pregnand Other (specify)	су			ate of deliver	y Day Year
2	ŝ	Part II. Other significant c	onditions cont	ributing to de	ath but not res	ulting in the u	nderlying cause gi	ven in Part I.		obacco use con Yes 2  No		e cause of death?
Completed									24a. Was a autop perfor 1 🗆 Yes	sy	Were autops prior to com death? 1 \( \subseteq \text{Yes} \) 2	sy findings available pletion of cause of
to To Ro	2	25. Was case referred to m examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Ho	28a. Date o		ER/Outpatien	t 3 DOA Other	4	Home 5 Resid			
Certificate		2 Accident 3 Suicide 6	Pending nvestigation Could not be determined	28e. Place o			M 1 □	Yes 2 No	28f. Location (S City or Tow		per or Rural I	Route Number,
Madical		(Check 2 Me only one) 3 Ce	dical Examine tifying Nurse	r: On the basis	of examination	n and/or invest	gation, in my opinic eath occurred at th	on, death occurre e time, date and	place, and due to the	nd place, and de e cause(s) and n	ue to the caus nanner as sta	se(s) and manner stated.
		29b. Signature and title of o	230	Sylpholeted carries	of death (Item	123a) (Type, P	29c. License	43894	16-1.51	29d. Date signe	02/	ay, Year)
	ľ	6/4ES	$OB_{(ear)}$	1LC	AO	201	East	Uner	estity	PORK	WOY	Rolts

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 5:12 AM Kincer W. Sept Kevin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1405 Shore Road Baltimore Co. Middle River 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday, Funeral ate or Direct Month, Day, Year 12. 3,1963 Days 1 X M 2 - F 217-82-1627 48 Maryland Yrs Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at **Funeral Director** Middle River 28a-f 1 Yes 2XX No MD Baltimore 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a United States 21220 1405 Shore Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. 1X Never Married 2 ☐ Married ģ 3 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mason Company Laborer 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jean M. Lee Kenneth P. Kincer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Shore Road Middle River, MD 21220 1405 Shore Road (Mother) Jean M. Lee 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 9/7/2011 Seven Valleys, PA Zion Lutheran Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 Signature of Funeral Service Licens Þ Dundalk, Maryland 7922 Wise Ave. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part 1. Enter the disease shock, or heart failure. Li Approximate Interval Between DISTASE Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence or). signed by the attending physician and defached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ Hospital or Attending Physician: The law requires that the death 24 hours after death.

Physician: Pruneral Director. After this certificate has been signed by the attention in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

(Check only one) 29b. Signature and tit

8

0

29c. License number

29d. Date signed (Month, Day, Year)

11

1-06530		Please Type or Print in Black Indelible Ink. Ensure All			
ean Lassiter		State of Maryland / Department of Health and Me 1- For State Certificate of Death		201	1 28590
		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of De	Reg. No.	3. Time of Death
Physicia ledical Examir	er	Sean Patrick Lassiter	Month August 3	Day Year 30, 2011	0026 hrs
		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital  4b. City, Town, or Location  Clinton	on of Death	4c. County of Dea Prince Georg	
Funeral		o. occur occurry realization		Birth(MM/DD/YYYY) 9. B	
Director		166-62-8150   1 X M 2 F   31 Yrs.   Months   Days   Ho	ours Min. 10/2	4/1979	ountry) PA
		Usual Residence of Decedent			Land Inside City Limite
y any	ı	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 Yes 2 K No
Aaryland 28a-f show 1 at once.	5	MD Prince George's Upper Marlboro		10 01	
th the Maryland 23a or 28a-f sho notified at once	ě	10e. Street and Number 10f. Zip Code	400	10g. Citizen of What Co	unuyr
th the 23s of		12814 Carousel Court 20772-64		U.S.A.	erican Indian, Black,
ath wi	Funer	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexic		White, etc.	mount mount brook
ter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No spec	cify:	Specify: W	hite
urs af	à l	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Giduring most of working life. DO N		16b. Kind of Business	s/Industry
5 72 hc ral Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Dut a sate	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Ĕ	12 Entertainment N	Manager ther's Name (First, Middle	Enterta	inment
Filed v Hygi		The factor of training to the factor of the	tia Sieber		
12 ld be Aenta narket	o Be	Robert Lassiter  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and It			te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	의	Altia Lassiter (Mother) 3205 St. John'			
e, N   and S   Health   item S	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery	, Date	20c. Location - City of	or Town, State
nt of l		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other SpecifyEntombment Greensburg Cath.	09/02/1		d, PA
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	ł	21. Signature of Fun- al Service Licensee 22. Name and Address of Fac	cility Wolfe-Vo	onGeis F.H	•
E F P P		5701 Lincol	n Ave., Fi	report, PA	The second secon
Physician		23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	as cardiac or respiratory a	arrest, shock, or heart	Approximate Interval Between Onset and
/Medicai ≞xaminer	Ì	Immediate Cause (Final disease a. Carisoprodol Tramadol Alprazola	m and Ethano	Intexicati	Death
		or condition resulting in death)  Due to (or as a consequence of):			
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  curants resulting in death). Last  Due to (or as a consequence of):			
ited d ansit		events resulting in death) Last Due to (or as a consequence or).  d.			
ox 68760, sath certificate be executed attending physician and for use as the burial - transit	dical	x UNPENDED ☐ AMENDED 23a, 27, 28a-f, per me, g919 9	9-9-11 sm		
760 cate b physi		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	tania prognana.	23d. Date of delive	ery Day Year
68 certificanting	ä	past 12 months?    1   Live birth   2   Fetal death   3   Ect	topic pregnancy	MOUNT	Day real
Box e death the atte	Physic	1 Yes 2 No 9 Unknown 9 Unknown			
of Vital Records, P.O. Box 68760, g.Physician: The law requires that the death certificate be then this certificate has been signed by the attending physicineral director, page 2 should be detached for use as the burineral director, page 2 should be detached for use as the burineral director, page 2 should be detached for use as the burineral director, page 2 should be detached for use as the burineral director.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		tobacco use contribute Yes 2 No 3 Pi	to the cause of death?
S, P			24a. W		autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	ompleted		au		completion of cause of
tal Reco	팃		1 ✔ Ye	s 2 No 1	
Vital   ysician: his certifi director,	Be (	pyrminer?	eath (Check only one)  Nursing Home 5	Residence 6 Ott	205
of Ving Physical Control of Vineral dir	P	The spiral of t	Taroning trainer of	pe how injury occurred	lei.
_ ≛ . < ≥	Ë	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2			
Sion Attenor r death ector: by the	cat	2 Accident Investigation   fd 8-30-11   fd 12:1/ am   28e. Place of Injury - At home, farm, street, factory, office building	ig, etc. 28f. Locatio		Rural Route Number, City
DIVI	Certification:	Suicide 6 X Could not be determined (Specify) Residence	_ or Towr	n, State) 12814 Ca Marlboro, Mo	rousel Ct.
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	nd place, and due to the ca	ause(s) and manner as s	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.			
L > F 3	ž	29b. Signature and title of certifier 29c. License num		29d. Date signed (A August 30, 201	
		Quel O.C.M.E.		August 30, 20	
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Balti	imore, MD 21223		
	ate				
Regis					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER DO 2019 03:30A M WILLIAM J. LEVINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SANCTUARY OF HOLY CROSS MONTGOMERY <u>BURTONSVILLE</u> Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 1 **X** M 2 □ F Months Hours Min. Country) 87 082**-**18-4779 Yrs NY **Director** 07/29/1924 Usual Residence of Decedent 10a. State 10b. County Medical Examiner must be notified at Director 10c, City, Town or Location 10d. Inside City Limits 28a-f 1 🗌 Yes 2 🗶 No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5620 VANTAGE POINT ROAD 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Y Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2¥XNo Specify: Specify: WHITE 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business industry permit. Page 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>EGISLATIVE ANALYST</u> SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **MEYER LEVINE** CELIA FURMANSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDITH LEVINE/WIFE 5620 VANTAGE POINT ROAD. COLUMBIA. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEM09/08/2011 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Kerroon Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 [] No Other: 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending work? 1 Yes 2 No 1 Natural Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined

Records, Division of Vital

State Registrar

DHMH 17 Rev 7/2009

24 hours

within 2 To the I

Medical

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sule 203 B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28592 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2011 Medical Lohman 1:24 PMM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 475 Torner Road Baltimore Essex Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Country) Maryland Months Hours (Month, Day, Yea 3/4/1947 Director 212-48-4834 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director should be filed within 72 hours after death with the Marylar and Mental Hygiene.
i and Mental Hygiene.
i is marked other than "natural", or items 23a or 28a-f sl raumatic event, the Medical Examiner must be notified. 1 Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 475 Torner Road 21221 S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1967 þ Baltimore, Maryland 21215-0036 1969 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 XDivorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Stewart Bethlehelm Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harold Ray Lohman injury or other traumatic Oneida Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Malinda Turansky (Daughter) <u>8031 Edwater Avenue Rosedale, MD 21237</u> 20a. Method of Disposition
1 ₹ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue ohn fort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ acrite respiratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OPD Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 9 Unknown the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 s autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1X Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner T. the Last of my knowledge of ellipsections of the time date and place, and oue to the cause(s) and manner as elected. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055157 Balanson 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BALANSON

9600

32. Registrar's Signature

Point Rd

Fort

Howard

MD

21052

North

	-	For State	1 100				d / Depa	rtment of	Healtl	n and N	/lental Hy	giene 0		28593
Physicia	n/	Registrar  1. Decedent's Name William		, , ,	ach Jr		067	incate or	Dean	1	2. Date of De Month	Day	Year	3. Time of Death 5:10 P M
Medic Examin		4a. Facility Name (if	not institution	, give street an	d number)			4b. City, Town,	or Location	on of Death	Septem	4c. Count	y of Death altin	1
Funeral Director		5. Social Security Nu. <b>217</b> 80 59		6. Sex 1 <b>X</b> M 2 [	7. Ag	ge (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		der 24 Hrs. s Min.	8. Date of Bir (Month, Da Aug. 25	th b, 1958	Cot	hplace (State or Foreign intry) ryland
/land f show ed at	tor	Usual Residence of 10a. State	10b. County	•			, Town or Loc							10d. Inside City Limits
a or 28a- be notifie	Funeral Director	Maryland  10e. Street and Num	ber	imore			MILO	lle Rive				10g. Citizen of	What Co	1  Yes 2 No
death with		25 Dogwoo	d Driv	12. Was	Decedent ed Forces?		3. 13. V	212 Vas Decedent of Yes, specify Cul	Hispanic	Origin? (Spe	ecify Yes or No-			rican Indian,
urs after ( tural", or al Examir	ted by	1 Never Marri	4 Divorced	ried 1 L If Ye Year	Yes 2 2 es, Give or Dates.			Yes 2 X N				Specif	ack, White y: <b>Wh</b>	nite
thin 72 ho ene. <b>than "na</b> he Medic	Completed	(Special Special Speci	cify only highe	nt's Education est grade comp Colle	ege (1-4 or	5+)	(Give k life. DC	ent's Usual Occu ind of work done O NOT use retired	during m	ost of work	ing	16b. Kind of I	Business I	
be filed wi antal Hygie ked other c event, t	o l	17. Father's Name (F		,	rh Sr		110	SC:IAMIC	1	other's Nam		Maiden Surnan		
12 should lith and Me 27 is mar r traumati		19a. Informant's Na Lucy Katr	me/Relations	nip (Type, Print,	)		1	g Address (Stree	t and Nur	nber or Run	al Route Numbe			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2 4 Donation	XCremation		I from State	.   0	lace of Disposemetery, crem	sition (Name of natory or other pl	ace)		Date	20c. Location	- City or	
permit. F Departm Importa any inju		21. Signature of Fun	neral Service L		lo-	1 2	22 B1	Name and Add	ess of Fa	cility unera	1 Home	P.A.	<u> </u>	and 21221
Physician/		Immediate Cause (I disease or condition	he disease, or t failure. List o Final	complications only one cause	that cause	d the death		r the mode of dy						Approximate Interval Between Onset and Death
Medical Examiner	Ļ	resulting in death)  Sequentially list cor	nditions.		ue to (or a	a consequ								7.00
cuted ind transit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	mediate lying injury	C	ue to (or as									
be eg	ical	resulting in death) L	_ast	d	ue to (or as	a consequ	ience of):							
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 4	es, outcome Live Birth Pregnant : Unknown	2 Feta	il death 3 🗌	Ectopic pregna Other (specify)	ncy				ate of del	ivery Day Year
uires that the signed by all die detac	ed by Pr	Part II. Other signifi	icant condition	ons contributin	g to death	but not res	ulting in the u	nderlying cause	given in P	art I.				the cause of death?
The law req ate has bee page 2 sho	Completed												prior to death?	topsy findings available completion of cause of
ysician: s certific director,		25. Was case referre examiner?  1  Yes 2		Hospital:	1 □ Inpat	ient 2 🗆	ER/Outpatien		hor	Death (Chec	, , , ,	idanca 6 Vot	her (Spec	ity) Hospie P
anding Physath. It: After this of funeral (	Certificate: T	27. Manne Death 1 Natural 2 Accident	5 Pendir	ng	Date of inju	ury	28b. Time of injury	28c. Inj				how injury occu		ny (105 ptc t
ital or Att. Irs after de al Directo led in by tl		3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 28e.	Place of Inj building, et			eet, factory, office				Street and Num wn, State)	ber or Ru	ral Route Number,
the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 only one) 3	☐ Medical E	xaminer: On t Nurse Practi	he basis of	examination	n and/or invest	eath occurred at	nion, deatl the time, o	n occurred a date and pla	t the time, date	and place, and d	lue to the	cause(s) and manner stated.
Norith		29b. Signature and t	title of certifier	08	To	/ 1	1 >	29c. Licer		er 7 / a > 4		29d. Date sign	ed (Monti	n, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

4105

st sute

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura Patel

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>, 2011 Physician/ September 15:58 Lennert Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 1600 Rita Road 8. Date of Birth (Month, Day, You May 14, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** . 1940 Days Hours Maryland **Director** 212-38-2266 1 🛛 M 2 🗆 F 71 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Dundalk Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n Funeral 21222 USA 1600 Rita Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status "natural", or iter Armed Forces?
1 X Yes 2 □ No Black White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Shipping 12 years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Lennert Louise M. Villa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important if item 27 is 1 any injury or other traumonce. 1600 Rita Road, Dundalk, Maryland Katherine M. Smith Daughter 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 8, 2010 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service License Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a, Part 1. Enter the diseas Approximate shock, or heart failure. Interval Between Immediate Cause (Final Physician/ larotic Cardio vascular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1 Natural 2 Accident injury 5 Pending work?
1 Pes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 8 2011 Registrar

5

15

150

Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 12:59 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CARROLL CARROLL HOSPITAL WESTMINSTER CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 223 46 7345 1 X M 2 D F Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No CARROL SYKESVILLE 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 6 items 23a Funeral USA G-4 MANOR DRIVE ITHER 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Medical Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural" 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PINEY RINGE and Mental Hygiene. is marked other than filed within Elementary/Seconday (0-12) College (1-4 or 5+) the ERVISOR ELEMENTALL other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ LIVESA FONIE EWE COLLINS WOR Page 1 and 2 should nent of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health au
Important: If item 27 is
any injury or other trau GAITHERMANDE 02 SYKESVILLE MO JRAN, LIVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Date WEST FRIENDY+IP, MO HAWN MISS, BAPCHCOM 10/2011 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ZUMBONN FITE MONCO. 6028 SYKESVILLERD DERSBURGMO 23a Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYUCARTIAL Immediate Cause (Final Physician/ minut disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Dunknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 1 Yes 2 No 28 N 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ဂ္ဂ 1 Yes 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | I within 2 To the I only one) 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) 7220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

SEP 0 8 201

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept <sup>D</sup>2011 Physician/ James Ronald Lay 12:52pM 5 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll 2006 Don Ave. Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 9-4-1938 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗚 2 🗆 F Months 214-36-8423 PA 73 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director Westminster Carroll 1 Yes 2X No MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 2006 Don Ave. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner. Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: white Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Fire Service Elementary/Seconday (0-12) College (1-4 or 5+) Fireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Raymond Lay Alma Lebo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Don Ave., Westminster, MD 21157 Sherry Anne Lay-wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Sykesville, MD South Carroll Crem 9-7-11 4 Donation 5 Other (Specify) Signature of Feneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 21157 nonual 254 E. Main St.,Westminster,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 77613 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) ☐ Pregnant Pregnant at time of death signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performe death? 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 5 Pending Natural 24 hours after death. Funeral Director: A ☐ Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 24321 mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fin Ksbug Md 21047 Bathman Blud 2059 Kunits 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

11-06669				nk. Ensure All (		jible.	
Michael Lawrence l	_uckeroth State State	•	•	f Health and Men	ital Hygiene	201	2859
	Registrar		Certificate o	f Death		g. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,La		.1.		2. Date of Death	Day Year	3. Time of Death 0935 hrs
	Michael Lawrence  4a. Facility Name (if not institution, gi		n I	4b. City, Town, or Location	September of Death	4c. County of Death	
	Howard County General I			Columbia		Howard	
Funeral	Social Security Number     6. S	ex 7. Age (In	rs. last birthday)		er 24Hrs. 8. Date of Birt		
Director	219-92-2854	ZM 2 F	47 Yr	Months Days Hours	Min. 1/20/	1964 Foreig	untry) MD
	Usual Residence of Decedent				1 -77		
w any	10a. State 10b. County	10c.	City, Town or Loca	tion			10d. Inside City Limits
f sho	MD Anne Art	ındel (	Glen Burn				1 Yes 2 X No
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Cou	ntry?
23a o	22 South Meadow			21060		USA	
er death with t	11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent Ever	lf.	as Decedent of Hispanic Ori Yes, specify Cuban, Mexican		White, etc.	ican Indian, Black,
F. Fu	3 Widowed 4 Divorce	1 Yes 2 Y	No 1	Yes 2 X No specify.		Specify: W1	nite
urs aft.	15. Decedent's Education (Specify of	or Dates:	d) 16a. Decede	nt's Usual Occupation (Give	kind of work done	16b. Kind of Business/	
5 72 ho al Ex	Elementary/Secondary (0-12)	College (1-4 or 5+)	during n	nost of working life. DO NOT	use retired)		
5-0036 led within 72 hour bour bygiene. other than "natu the Medical Exan Completed	12		Tran	sportation Co		Movie	
Hygi Hygi Co	17. Father's Name (First, Middle, Las	1)			r's Name (First, Middle, N		
1121 Id be fill fental I narked event,	Larry Luckeroth  19a. Informant's Name/Relationship (	Turno Print )	T 40h Mailin	g Address (Street and Nur	salie Righte		Tin Code)
ID 21 should and Mei 7 is man	Mrs. Linda Luck			South Meadow		n Burnie, N	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23s or 28s-f show injury ar other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disposition		20b. Place of Dispo	sition (Name of cemetery,	Date	20c. Location - City or	
DOF ages 1 at of F other	1 Burial 2 Cremation 3		crematory or o		0/0/2011	Glen Buri	nio MD
it. Partmet artmet ortan	4 Donation 5 Other Specification Signature of Funeral Security Lices	r: C	zen Have	n Mem. Park Name and Address of Facilit	9/9/2011 v Singleton	Funeral &	remation
Dep Dep	MATL	- MO270		ervices, PA l			
Physician	23a Part i. Enter the disease or comfailure. List only one cause on e		eath. Do not enter	the mode of dying, such as o	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner			otic Card	iovascular D	isease		Death
	or condition resulting in death)	Due to (or as a consequer	ice of):				
<b>a</b>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	nce of):				
: :	oause. Enter Underlying Cause (Disease or injury that initiated						
ted Insit Examiner	events resulting in death) Last	Due to (or as a consequer	nce of):				
lox 68760, eath certificate be executed the strending physician and for use as the burial - transit /sician/Medical Ex	X UNPENDED		,per me,	3919 9-16-11	sm		
60, ate be hysici e buni	IF FEMALE:	23c. If yes, outcome of				23d. Date of deliver	V
S87 rtifica ling pl	23b. Was decedent pregnant in the past 12 months?	1 Live birth		etal death 3 Ectopi	c pregnancy		Day Year
OX ( ath ce attend or use	1 Yes 2 No 9 Unknow	Pregnant at time	of death 5 0	ther (Specify)		1	
). Box 68760, the death certificate be by the attending physicioned for use as the bun Physician/Med	Part II. Other significant conditions	3 Oliviowii	not resulting in the	underlying cause given in P	art I 23e. Did to	bacco use contribute to	the cause of death?
cords, P.O. B law requires that the d has been signed by the 2 should be detached opleted by Phy						2 No 3 Pro	
ds, equir een si ould b					24a. Was a		utopsy findings available
Records,  The law requires freate has been signage 2 should be Completed					autop perfor	med? death?	completion of cause of
tal Records cian: The law requi certificate has been cctor, page 2 shoulde Be Complete	25. Was case referred to medical			26.Place of Death	(Check only one)	2 No 1 Y	es 2 No
Vital bysician this cert didirecto		Hospital: 1 Inpatient	2 FR/Outpatier			Residence 6 Othe	r;
n of hing Phy After thuneral uneral	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of			now injury occurred	
ion tendir eath.	1 Natural 5 Pending 2 Accident Investiga			1 Yes 2	] No		
Vision At Direct in by	3 Suicide 6 Could no	28e Place of Injury -	At home, farm, stre	et, factory, office building, e	tc. 28f. Location (S or Town, S		ural Route Number, City
Division o Bivision of Spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	4 Homicide determine	ed (Specify)			or rown, s	late)	
	146.4			irred at the time, date and plation, in my opinion, death o			
To the Hr within 24 To the Fu completely	29b. Signature end title of certifier	and manner stated.	ion analor investige	29c. License number			
				O.C.M.E.		29d. Date signed (Mo September 5, 20	•
	30. Name and address of person who	completed cause of doct	(Item 22a)	J. J. W. L.	-	300.0111001 0, 20	
28	Laron Locke MD. Assis	stant Medical Examir		altimore Street, Baltir	more, MD 21223		
State		32. Pigistrans Si					
Registra			1.1	wel			
DHMH 17 Rev 1/2001	OCM	E	ORIGINA	<b>AL</b>			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 28598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEP Physician/ Year HEL 03:27 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, 09-12-7. Age (In vrs. last birthday) If Unde 9. Birthplace (State or Foreign **Funeral** 212-28-4903 1 🗆 M 2 🔀 F Hours Min. **Director** Usual Residence of Deceden ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MDBALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Avenue USA 2121 ECHODALE permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLack 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) MEDICAL NURSES ALDE 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GAMBLE FANNIE COUSAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas + Levance Myers 3107 ECHODALE AVE. BALTO, MD. 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State ARBUTUS CEMETERY 12/11 BATIMORE, MO Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERALSOKS 4905 YURK RUAD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CERERO

Due to (or as a consequence of): Physician, VASCUL disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to or as a consequence of: cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Yes 2 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) YASU MEKONEN, M.D SEPTEMBER 06, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEKONEN, M.D Boulevard 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

SFP 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's:Name (First Middle Last 2. Date of Death Som temper Physician/ Medical cility Name (if not institution or Location of Death 4c. County of Death Examiner N/A 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 11/05/1950 Min. Days 1 X M 2 🗆 F 60 Yrs Director 174-46-1328 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland at Director be notified 1 X Yes 2 No PA Lakawanna Jermyn 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 18433 U.S.A. Examiner must 130 Miller Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 1 Yes 2 X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Construction Carpenter Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Schultz permit. Page 1 and 2 should be Elizabeth Matala Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tract 130 Miller Road, Jermyn, PA 18433 Carolyn Matala, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/09/2011 Joseph Cemetery Scott Two.PA 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 6 11 Medical Due to (or as a consect nce of) Examiner CIP Secrentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consect ence of transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events ng physician ar as the burial-to resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? for Year Pregnant at time of death 2 No the Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient After this 27. Mann of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural iniury 5 Pending after death. Director: Af 1 Tyes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 🗌 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Day, Year) 101 completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Shirley Mae Moore 09 2011 8:47P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 402 Baylor Road Glen Burnie Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. nth, Day, Year) /29/1935 245-50-1310 NC **Director** Yrs. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A. 402 Baylor Road 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Restaurant 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mae Bennett Wilson Loni Julius Doss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Tricia Moreau / Daughter 7411 Hawkins Drive Hanover, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 09/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician monusema disease or condition 1000 Medical resulting in death) Due to (or as a const quance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Qid tobacco use contribute to the cause of death? Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 24 hours after death. Funeral Director: After this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 2

101

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

mapolis

10053393

Erilka Larson

2111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 28601 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year September aceyras 1410 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimor Johns HOPKIN Hospital itu Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Hours Min Cuba 267-72-3177 73 Yrs February 7, 1938 Director Usual Residence of Decedent or 28a-f show notified at 10b. County the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery 1 Yes 2 X No Potomac 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral death with 11000 Seven Hill Lane 20854 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian han "natural", or it 9 Medical Examine Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Specify.White Cuban 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hr ih and Mental Hygiene. 27 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Self-Employed Architect Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic of Silvio R. Valdes Margarita J. Esquerre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramon E. Maceyras/Husband 11000 Seven Hill Lane, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 10. Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2011 Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 22. Name and Address of Facility Robert A. P. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M01498 Bethesda, Maryland 20814

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metry tric honoreas Canch disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that britished as or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician of for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 N After this certificate has 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide Investigation М within 24 hours after deatl completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinating and/or inventioning in a process Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year, September 6, 2011

Registrar

DHMH 17 Rev 7/2009

State

Q

30. Name and address

31. Date filed (Month, Day

person who completed caus

HUSANN

N

Baltimore mp

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 28602 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 2011 9:40A Ruth Bell McCormick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 K Months Hours 0/307t0 Pay/1926 S. Carolina 212-22-3174 85 **Director** Usual Residence of Decedent Show 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 28a-f 1 ▼ Yes 2 □ No MD N/A Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a with 702 Luzerne Ave. 21205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. Yes 2 No Yes, Give 6 Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black "natural", 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. 12th Grade SEPTEMBER College (1-4 or 5+) Supply Operation John Hopkins Hospita Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Brian Wilkes Pearl Morant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traignose. 2802 Elsinore Ave., Baltimore, MD 21216 Stanley Scurry(cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Garrison Forest 09/08/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 労働家管的Mddfs of Ferown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ CANCE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-transi Due to (or as a consequence of): Physician/Medical MeCORMICK Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performe 2 🗆 No 1 Yes Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending Investigation within 24 hours after deatl To the Funeral Director. completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State Registrar

7:40am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		artment of F rtificate of D		nd Mental H	ygiene Reg. No.	1 28603
			Decedent's Name (First, Middle,	, Last)		timodito of E	Journ	2. Date of D	eath	3. Time of Death
	Physicia Medic		ARLINE	NADLER				SEPTEM	IBER 04, 20	11 8:55 P <sup>M</sup>
	Examir	er	4a. Facility Name (if not institution,	,		4b. City, Town, or		Death	4c. County of E	Death
	Funeral		6 UPLAND ROAD,  5. Social Security Number	6 Sex 7 Age //n	yrs. last birthday)	BALTI If Under 1 Year	If Under 24		N/A sirth 9.	Birthplace (State or Foreign
	Director		386-16-0919	1 M 2 XF 8		Months Days	Hours		71924	Country) NY
	nd now at	_	Usual Residence of Decedent  10a, State 10b, County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	farylar 3a-f sl iffied	Director	MD N/A	ı	BALTIMO					1 ¥ Yes 2 □ No
	the N or 28	٥	10e. Street and Number		DILLI	10f. Zip Code			10g. Citizen of Wha	t Country?
	h with	Funeral	6 UPLAND ROAD	BLDG. 1, AP		2121			USA	
	r deat or iten siner i		11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Ever Armed Forces? 1  Yes 2 No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin' ın, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
036	rall', c	q pa	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	i	1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
5-0	2 hour	plet		t's Education st grade completed)		dent's Usual Occup		workina	16b. Kind of Busin	ess Industry
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show er than Medical Examiner must be notified at	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	life. D	O NOT use retired) BRARIAN	3	3	PIIRLTO	SERVICE
d 2	d y	Be	17. Father's Name (First, Middle, La		1 11.	DIVARLEN	18. Mother's	Name (First, Middl	e, Maiden Sumame)	BERVIOL
ylar	should be filed wit n and Mental Hygie 7 is marked other raumatic event, the	은	HYMAN	LEVINSON	T		MIN	NIE		FELL
Maryland	1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationsh			-			ber, City or Town, State	, Zip Code)
re,	F Healt		JOAN ROYALS/D  20a. Method of Disposition	2	20b. Place of Dispo	2 NORTHWA	-	Date Date	D 21218 20c. Location - Cit	y or Town, State
mo	0 = =		1 ☐ Burial 2 💆 Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State pecify)	cemetery, crer	matory or other plac ${\sf REMATION}$ ,		9/07/2011	HAMPSTE	EAD, MD
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Services LI		22	2. Name and Addres	ss of Facility	SOL LEVI	NSON & BRO	-
	40 = 60		23a, Part 1, Fifter the disease, or	complications that caused the					PIKESVILLE,	MD 21208 Approximate
	Physician/		shook, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line.						Interval Between Onset and Death
		10.1	resulting in death)	a						
Sec.	Medical		resulting in death)	Due to (or as a co	onsequence of):	-Ł.	,			-
and a	Medical Examiner	er		b. Aont	tic 5	tenus	213			5 years
(mag)	Examiner	aminer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a co	tic 5	tenus	21.5			5 years
and a second	Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate	b. Aont	onsequence of):	tenus	21.5			Syears
094	Examiner sician and purial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or linjury that initiated events	b. Due to (or as a con	onsequence of):	tenus	21.5			Syears
09289	Examiner sician and purial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or linjury that initiated events	b. Due to (or as a cold d. Due to (or as a cold d. 23c. If yes, outcome of p.	onsequence of):				23d. Date o	
Box 68760	death certificate be executed  the attending physician and ed for use as the burial-transit	sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate for the conditions of the	b. Due to (or as a col	onsequence of):  onsequence of):  oregnancy  Fetal death 3				23d. Date o Month	
Box 687	the death certificate be executed to be the attending physician and detached for use as the burial-transit of	Physician/Medical	Sequentially list conditions, if any, leading to immediate for the conditions of the case (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a cold d. Due	onsequence of):  onsequence of):  oregnancy  Fetal death 3 [ ne of death 5 [	☐ Ectopic pregnand	эу Э	23e. Dic	Month	f delivery
P.O. Box 687	that the death certificate be executed  the death of the attending physician and  the detached for use as the burial-transit  o	by Physician/Medical	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a cold d. Due	onsequence of):  onsequence of):  oregnancy  Fetal death 3 [ ne of death 5 [	☐ Ectopic pregnand	эу Э	1	Month  I tobacco use contribut	f delivery Day Year
P.O. Box 687	equires that the death certificate be executed  een signed by the attending physician and  hould be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a cold d. Due	onsequence of):  onsequence of):  oregnancy  Fetal death 3 [ ne of death 5 [	☐ Ectopic pregnand	эу Э	1 [	Month  I tobacco use contribut  Yes 2 No 3 [ is an 24b. Wentopsy	f delivery Day Year te to the cause of death?
P.O. Box 687	The law requires that the death certificate be executed the law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit of	Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown  Part II. Other significant condition	b. Due to (or as a cold d. Due	onsequence of):  onsequence of):  oregnancy  Fetal death 3 [ ne of death 5 [	☐ Ectopic pregnand	эу Э	1 [	Month  I tobacco use contribut  Yes 2 No 3 [ Is an 24b. Wernopsy prior deat	f delivery Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available t to completion of cause of
P.O. Box 687	The law requires that the death certificate be executed the law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit of	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions 25. Was case referred to medical examiner?	b. Due to (or as a cold of the following section of the following secti	onsequence of):  oregnancy Fetal death 3 [ ne of death 5 [	☐ Ectopic pregnand ☐ Other (specify) ☐ underlying cause given	ven in Part I.  ace of Death (	1 ☐ 24a. Wa au' pei 1 ☐ Ye	Month  I tobacco use contribut  Yes 2 No 3 [  Is an prior opsy formed?    S 2 No 1 [  I tobacco use contribut  4 deat    1 contribut  1 contribut  1 contribut  1 contribut  2 deat    1 contribut  1 co	f delivery Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th?  Yes 2 No
P.O. Box 687	The law requires that the death certificate be executed the law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes No  27. Manner of Death	b. Due to (or as a cold of the details of the detai	onsequence of):  onsequence of):  oregnancy Fetal death 3 [ ne of death 5 [  not resulting in the unit of the control of the c	☐ Ectopic pregnand ☐ Other (specify) ☐  Inderlying cause give  26. Pi  A ☐ DOA Other  28c. Injun  1 ☐ 28c. Injun	even in Part I.  ace of Death ( er: 4 □ Nursi y at	1 E  24a. Wa auti pet 1 T Ye  Check only one)	Month  I tobacco use contribut  Yes 2 No 3 [ is an 24b. Wentopsy	f delivery Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th?  Yes 2 No
P.O. Box 687	ng Physician: The law requires that the death certificate be executed the trins certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold of the	onsequence of):  onsequence of):  oregnancy Fetal death 3 [ ne of death 5 [  not resulting in the unit of the second of the seco	□ Ectopic pregnand □ Other (specify) □ underlying cause given the second secon	even in Part I.  ace of Death ( er: 4 □ Nursi y at	24a. Wa auting the properties of the properties	Month  I tobacco use contribut  Yes 2 No 3 [  Is an prior opsy formed? 1    sidence 6 Other (5)	f delivery Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th?  Yes 2 No
P.O. Box 687	ng Physician: The law requires that the death certificate be executed the trins certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold of the property of the	onsequence of):  onsequence of):  onsequence of):  oregnancy  Fetal death 3 [  ne of death 5 [  and resulting in the unit resulting	□ Ectopic pregnand □ Other (specify) □ underlying cause given the second secon	even in Part I.  ace of Death ( er: 4  Nursi y at	24a. Wa auting the properties of the properties	Month  I tobacco use contribut  Yes 2 No 3 [  Is an prior opsy formed? 1    sidence 6 Other (5)	f delivery Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available t to completion of cause of th? Yes 2 No
Records, P.O. Box 687	ng Physician: The law requires that the death certificate be executed the trins certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a cold of the	onsequence of):  onsequence of):  onsequence of):  oregnancy  Fetal death 3 [  ne of death 5 [  and resulting in the unit resulting	□ Ectopic pregnand □ Other (specify) □ Inderlying cause given the state of the sta	even in Part I.  ace of Death ( er: 4 \sum Nursi y at ?? Yes 2 \sum No	24a. Wa put pel	Month  I tobacco use contribut  Yes 2 No 3 [  Is an ropsy of tomed?   24b. Wen prior deat    Sidence 6 Other (Se how injury occurred    (Street and Number of town, State)	f delivery Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available r to completion of cause of h? Yes 2 No  Specify)  r Rural Route Number,
P.O. Box 687	ng Physician: The law requires that the death certificate be executed the trins certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold of the property of the	onsequence of):  onsequence of):  onsequence of):  oregnancy Fetal death 3   Fetal death 5    not resulting in the understand in the under	□ Ectopic pregnand □ Other (specify) □ underlying cause given to a □ COA  of the late of	ey ven in Part I.  ace of Death ( er: 4 \sum Nursi y at ?? Yes 2 \sum No n, date and pla on, death occu e time, date an	24a. Wa aput per	Month  I tobacco use contribut  Yes 2 No 3 [  Is an priority of the residence 6 Other (See how injury occurred of the cause(s) and manner as and place, and due to the cause(s) and manner and the cause(s) and manner as and place, and due to the cause(s) and manner and place, and due to the cause(s) and manner as and place, and due to the cause(s) and manner and place, and due to the cause(s) and du	f delivery Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No  Specify)  r Rural Route Number, s stated. the cause(s) and manner stated. er as stated.
P.O. Box 687	The law requires that the death certificate be executed the law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit of	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cold of the	onsequence of):  onsequence of):  onsequence of):  oregnancy Fetal death 3   Fetal death 5    not resulting in the understand in the under	□ Ectopic pregnand □ Other (specify) □ underlying cause given to 3 □ DOA Other    M	ey ven in Part I.  ace of Death ( er: 4 \sum Nursi y at ?? Yes 2 \sum No n, date and pla on, death occu e time, date an	24a. Wa aput per	Month  I tobacco use contribut  Yes 2 No 3 [  Is an priority of the contribut of the contri	f delivery Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No  Specify)  r Rural Route Number, s stated. the cause(s) and manner stated. er as stated.
P.O. Box 687	ng Physician: The law requires that the death certificate be executed the trins certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	Medical Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate for the first of high cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	onsequence of):  onsequence of):  oregnancy Fetal death 3 [ ne of death 5 [  and resulting in the unit resulti	□ Ectopic pregnand □ Other (specify) □ Inderlying cause given to a long property of the prope	ace of Death (er: 4 \sum Nursi y at ?? Yes 2 \sum No	24a. Wa autiple 1 To Ye  Check only one)  Ing Home 5 Are  28d. Describe  28f. Location City or To  ce, and due to the red at the time, dat id place, and due to	Month  I tobacco use contribut  Yes 2 No 3 [  Is an prior deat of the contribut of the cause(s) and manner as and place, and due to the cause(s) and manner and 29d. Date signed [M. ]	f delivery Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No  Specify)  r Rural Route Number, s stated. the cause(s) and manner stated. er as stated.
P.O. Box 687	ng Physician: The law requires that the death certificate be executed the trins certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of	Medical Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate  Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	onsequence of):  onsequence of):  oregnancy Fetal death 3 [ ne of death 5 [  and resulting in the unit resulti	26. Plant 3 DOA Other (specify) 26. Plant 3 DOA Other work M 1 DOA Other work M 29c. Injury work M 29c. License 1326. Depth of the stigation, in my opinic death occurred at the time occurred at the time 1326. License 1326. Lic	ace of Death (er: 4 \sum Nursi y at ?? Yes 2 \sum No	24a. Wa autiple 1 To Ye  Check only one)  Ing Home 5 Are  28d. Describe  28f. Location City or To  ce, and due to the red at the time, dat id place, and due to	Month  I tobacco use contribut  Yes 2 No 3 [  Is an prior deat of the contribut of the cause(s) and manner as and place, and due to the cause(s) and manner and 29d. Date signed [M. ]	f delivery Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available roompletion of cause of th? Yes 2 No  Specify)  r Rural Route Number, s stated. the cause(s) and manner stated. or as stated. Jonth, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT W. ORTMAN. 5, Year 201 JR. SEPTEMBER 10:00PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat 6739 WOODLEY ROAD BALTIMORE DUNDALK If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 216-92-2888 Days Hours Director 1**X** M 2 □ F 48 7-10-1963 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location the Medical Examiner must be notified at Director MD BALTIMORE DUNDALK 1 Yes 2 X No P 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral and Mental Hygiene. is marked other than "natural", or items 23a 6739 WOODLEY ROAD 21222 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. þ 1 XNever Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 INSTALLER CARPET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT ORTMAN, SR. LORRAINE LUTZ ) Lepartment of Health and Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
31 FALLS ROAD NORTH EAST, MD 21901 ROBERT ORTMAN, SR/FATHER NORTH EAST, MD 31 FALLS ROAD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State METRÓ CREMATORY 9-9-2011 4 Donation 5 Other (Specify) CATONSVILLE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ore of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Asphyxia Physician/ disease or condition resulting in death) hanging Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 \( \subseteq \text{No.} \) Hospital 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) C9/05/201 Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Suicido work? 1 ☐ Yes 2 XNo 1 🔲 Natural injury 5 Pending 2200 P M Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number of Rural Royle Number City of Town, State) Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) 140 mg 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and clear and death of the cause(s) and manner stated. completely (Check 29c. License number D1866 Name and address of person who completed cause of death (Item 3a) (Type, Print) MILITELLO ASILLOT MP 6TRIMBLE 31. Date filed (Month, Day, Year) SEP 0 8 2011 Registrar DHMH 17 Rev 06-2011

8

N

N

102

1051

160

S

State of Maryland / Department of Health and Mental Hygienes 28605 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0 8 Month 29<sup>Day</sup> Physician/ 4:30 am Mamie D. Patterson 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mariner Health Center Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TXF Months Davs Hours Min 0171371924 Country) Virginia 87 Yrs **Director** 226–24–6553 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Anne Arundel 1 Yes 2 X No Glen Burnie MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a7355 Furnace Branch Road 21061 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black. White, etc. 9 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Textiles 9 Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Belva Lester William Dewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Patterson, Sr. Son 554 Barbour Road, Martinsville, VA 24112 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Patterson Family Cem 9/1/2011 Franklin County, VA 4 ☐ Donation p ☐ Other (Specify) 22. Name and Address of Facility Lynch Conner Bowman Funeral Home ral Service Licensee MOIII2 140 Floyd Ave, Rocky Mount, VA 24151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Damen disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Examine Due to for as a nonsequence on il any, leading to immedicause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ rneumonia Aspiration 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No. 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle of certifier 29c. License number 51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Ambalavanar 7845 Oakwood Road Clen Burnie MD21061 31. Date filed (Month, Day, Year) State SEP 0 8 2011

DHMH 17 Rev 7/2009

Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 28606 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 201 Jacqueline May Perdue 1:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Square Rosedale Baltimore Hospita Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under **Funeral** 1 □ M 2 😿 F Days Hours Director 216-40-0047 68 Marvland Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Joppa 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 828 Joppa Farm Road 21085 United States or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Ferdue, Jacqueline Baltimore, Maryland 21215-0036 Black, White, etc. Completed by 1 Never Married 2 XMarried 1 ☐ Yes 2 XNo Specify: "natural", Specify: 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event "to once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Warren Foster Sarah F. Eckert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Jean Burleson(Daughter) 1600 Clayton Road Joppa, Maryland Method of Disposition

→ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/7/2011 Joppa, Maryland Trinity Lutheran Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signatury of Funeral Service Licensee 22. Danda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease shock, or heart failure. Li , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ MOC disease or condition resulting in death) Medical Due to (or as a consequence of) and Pancretic Abscess **Examiner** Pancreatitis Sequentially list conditions, Due to (or as a con equence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and I for use as the burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ □ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signate bage 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? performed No 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 📈 No မ 1 

Inpatient 2 

ER/Outpatient 3 

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) of certifier 29d. Date signed (Month, Day, Year) 6000 mD of person who completed cause of death (Item 23a) (Type, Print) 10 V 9000 Franklin more Baltmore, MD Drive

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

2011

SFP 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28607 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy M. Pattison 09/03/2011 10:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 10,50an 1 🗆 M 2 🔀 F Hours Maryland 09/07/1933 215-30-6015 **Director** 77 Usual Residence of Decedent 28a-f shov 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8225 Park Haven Rd. 21222 3,2011 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 🙀 Married "natural", or þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Josepharment of Health and Mental Hygiene. Important: If frem 27 is marked other than any injury or other traumatic eventral once. Elementary/Seconday (0-12) College (1-4 or 5+) SEPTEMBER 12 Receptionist <u>Medical</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Mary Koporec Benarick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixon R. Pattison (husband) 8225 Park Haven Rd. Dundalk, MD, 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) eart of Mary 09/06/2011 Dundalk, Maryl 22. Name and Address of Facility Duda-Ruck Funeral Home of Sacred Heart of Mary Maryland Si na re of Funeral Service Lic 21222 Dundalk, Inc. 7922 Wise Ave. Dundalk, MD. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Records, 24a. Was an Were autopsy findings available prior to completion of cause of or Attending Physician; The law autopsy death? 2 No 1 Yes of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division after death Investigation completed filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28608 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 1 □ M 2 ₩ 28a-f show death with the Maryland 10a. State City. Town or Location 10d. Inside City Limits notified at Funeral Director 1 Yes 2 No ŏ 10e, Street and Numb 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be r 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 within 72 hours after Yes If Yes, Give Year or Dates 1 Yes 2 No Specify Blac Completed 3 MWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) lth and Mental Hygier 27 is marked other t r traumatic event, the 10 Be Father's Name (First, Middle, Last, 2 27 Important: If item 2 any injury or other Baltimore, of Disposition (Name of ☑ Burial 2 ☐ Cremation al from State 4 ☐ Donation 5 ☐ Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest shock, or heart failure. List only one cause of yeach line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ umon disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year should be detached the Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate Yes Yes Division of Vital or Attending Physician: funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Certificate: To Be examiner? ice Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar 30. Name

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland Registrar		artment of Healt tificate of Deati			iene eg. <b>\2</b> 0	28609		
	Physicia Medic	al	Decedent's Name (First, Middle, Last)  LENA RADALINSKY  4a. Facility Name (if not institution, give street and number)				2. Date of Death Month SEPTEMB	ER 02 2011	3. Time of Death 02:15P M		
	Examin Funeral Director	er	TUDOR HEIGHTS  5. Social Security Number  6. Sex 1 M 2X F 7. Age (In yrs. last	birthday) Yrs.	4b. City, Town, or Location  RAI TI  If Under 1 Year If Under 1 Year Hour	MORE	8. Date of Birth	9. Bi	ORE CITY Intholace (State or Foreign ountry)  NY		
	aryland a-f show ified at	Director	Usual Residence of Decedent  10a. State	Town or Loc	BALT IMO	RE			10d. Inside City Limits 1   ✓ Yes 2   No		
	s 23a or 28 uust be not	Funeral Dir	10e. Street and Number 7218 PARK HEIGHTS AVENUE, #222		10f. Zip Code 212	08	1	0g. Citizen of What C			
9800	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene the art is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates.	- 1	Vas Decedent of Hispanic f Yes, specify Cuban, Mexi		sify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: W			
21215-0036	d within 72 ho ygiene. her than "nal it, the Medica	Be Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+) 12	(Give I life. DO	lent's Usual Occupation kind of work done during n O NOT use retired)	nost of workin	g	16b. Kind of Business	. Kind of Business Industry  CLOTHING		
yland	should be filed and Mental H is marked ot raumatic even	To B	17. Father's Name (First, Middle, Last)  JACOB SHLIAN			OUSSIE		BORSTEIN			
e, Mai	permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m any injury or other traumonce.		SYLVIA HIRSCH/SISTER	3113	g Address (Street and Nur MARNAT ROAD	, BALT	IMORE,	MD 21208			
Baltimore, Maryland			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW	netery, crem MONTI	sition (Name of natory or other place) EFIORE	09/04	/2011	20c. Location - City o	NY		
Ba	Depar Depar Impo any ir		21. Signature of Funeral Service Licensee	89	Name and Address of Fa	STOWN R	OAD, PI	KESVILLE,			
	Physician/ Medical		23a. Part : Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to or as a condatuen		er the mode of dying, such		respiratory arres		Approximate Interval Between Onset and Death		
	Examiner	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequen								
0	be e siciar burit	ical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequent death)	ice of):							
Box 68760	The law requires that the death certificate ate has been signed by the attending phy: page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy in the past 12 months? 1 ☐ Ves 2 ☐ No 4 ☐ Pregnant at time of dea	23d. Date of do	elivery Day Year						
P.O.	v requires that the de s been signed by the a should be detached	þ	9 Unknown  Part II. Other significant conditions contributing to death but not resulti	ing in the u	nderlying cause given in P	Part I.			use contribute to the cause of death?		
Division of Vital Records,	sician: The law req certificate has bee irector, page 2 shoi	• Completed	25. Was case referred to medical		00 Plane (1	David (Obs.)	24a. Was ar autops perform 1  Yes 2	prior to death?	utopsy findings available completion of cause of		
f Vita	Physicia this cert ral direct	To B	examiner? 1  Yes 2 No Hospital: 1  Inpatient 2 ER		Other	Death (Check  Nursing Hon		ince 6 Other (Spe	cify) Line		
sion o	To the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	1	Bb. Time of injury	28c. Injury at work?  M 1 1 Yes 2	2 🗆 No		w injury occurred	,		
Divi	spital or A ours after ieral Dire filled in b		4 Homicide determined building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge				City or Town	,	· .		
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2   Medical Examiner: On the basis of examination ar only one) 3   Certifying Nurse Practioner: To the best of my kr	nd/or invest	igation, in my opinion, deatleath occurred at the time, o	th occurred at t date and place	the time, date and	d place, and due to the	cause(s) and manner stated.		
	<b>5</b>		29b. Signature and title of certifier		29c. License numbe		2'	9d. Date signed (Mon	th, Day, Year)		
			30. Name and address of person who completed cause of death (Item 23			P	ė, ster	stown, o	~ D 2 113(		
	Stat Registra	_	31. Date filed (Month, Day, Year)  SEP 0 8 2011	far	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 286 | 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 1920 M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Himore yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 216-68-6980 **Funeral** 9. Birthplace (State or Foreign 1 □**X**M 2 □ F Months Days Hours Ju 19th, 044, 19957 Count **Director** Yrs Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD notified N/A Baltimore 28a-f 1 XYes 2 No 5 10e, Street and Number 10f. Zip Code must be r 10g, Citizen of What Country? Funeral 1203 N. Decker Avenue 21213 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ŏ þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 filed within 72 hours after Specify: Black 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Value City Elementary/Seconday (0-12) College (1-4 or 5+) the Retail Manager 10th N/A of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last)
Willie Reynolds 18. Mother's Name (First, Middle, Maiden Surname)
Rose Martin ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Fore Ct. Baltimore, MD 21221 Rose Reynolds/Mother 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Mt. Carmel Cem 9/12/2011 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beyerly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 Signature f Funeral Service Dicensee 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secusifially lict conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burla Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No signed by the a d be detached f 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director; After this certificate has autopsy performed? 2 🗆 No 1 Tes Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital 2 | No Other: 2 1 ☐ Inpatient 2 🕼 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ti

2

State Registrar

DHMH 17 Rev 7/2009

WOIFE

St Baltimore

1000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORDAN

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene  1-State Registrar  Certificate of Death  Reg. N2 0   286														
			Registrar  Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death									3. Time of Death	_				
	Physicia		Helen Louise Stonesifer  Month Day Year September 5, 2011 12:18 A.M											1			
-	Medio Examir												112.10 A.				
1			Dove Hous		20v 17 A	ao (la um la	at hirthdow		stmins		O Data of Dia						
	Funeral Director		219-20-3	568 1	1 □ M 2XXF 7.A	ge (In yrs. la	85 Yrs.	Months Day		Min.	8. Date of Bir (Month, Da Jan• 1	y, Year	926	Coun Mar	place (State or Foreigr stry) yland	1	
	nd now	ايا	Usual Residence of 10a. State	10b. County		10c. City	, Town or Loc	ation	-					1	10d. Inside City Limits		
	arylar a-fsl fied	sct	Maryland	Carro	11		ampste								¹XIXI Yes 2 □ No		
	or 28	ă	10e. Street and Nun				ampbec	10f. Zip Code	•			10a. C	Citizen of Wh	nat Cour	ntry?		
7	n with t ns 23a nust be	Funeral Director	1006 Sout	th Main S				210					d St eric	ates ates a			
0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If frem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	व	11. Marital Status 1 □ Never Marr 3XXWidowed	ied 2  Married	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates.	Ever in U.S X No	- 1	Vas Decedent of Yes, specify Cu			cify Yes or No- Rican, etc.)			White,			
15-(	/2 hou n "nat Aedica	Completed		15. Decedent's E ecify only highest gr	rade completed)		(Give k	ent's Usual Occ ind of work don O NOT use retire	e during mo	st of worki	ng	16b.	Kind of Bus	iness In	dustry		
212	vithin jene. er tha the N	ပ်	Elementary/Second 7th	onday (0-12)	College (1-4 or	5+)		House Ke	,				Cleani	ing	Houses		
D.	I Hyg		17. Father's Name (I	First, Middle, Last)					18. Mot	her's Name	e (First, Middle,	Maide	n Surname)				
/lar	denta Menta arked tric er	우	George He	enry Dieh	1				Mary	y Bel	le Ying	Jlin	ıg				
Baltimore, Maryland 21215-0036	d 2 Shoull ealth and 1 n <b>27 is m</b> a er trauma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Catherine Abbott (Daughter)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4314 Black Rock Rd., Upperco, MD 21155														
ore	e 1 and of Hear or othe		20a. Method of Disp		☐ Removal from Stat		lace of Dispos	sition (Name of atory or other p	lace)	Sep	Date 8,	20c.	Location - C	City or To	ty or Town, State		
ti Ei	tr. Pag tment tant: jury	Ш	4 Donation	5 Other (Speci	ify)		Luthe	ran Cem	etery	2	011	Ma	anches	ter,	Maryland		
Bal	Depar Impor any in		21 Signature of Fur	aryke Licen	in.			Name and Add							el, P.A.		
			23a. Part 1. Enter t	he disease, or com	plications that cause one cause on each li	ed the death	. Do not ente	r the mode of d	ying, such a	s cardiac o	r respiratory ar	rest,			Approximate Interval Between		
PI	nysician/		Immediate Cause ( disease or conditio	Fi <i>n</i> al	a. Subdura		atoma			1	P				Onset and Death		
	Medical Examiner		resulting in death)	•	Due to (or as					TY ?	27						
		iner	Sequentially list co if any, leading to im	nditions, nmediate	b. Due to (or as	s a consequ	ence of):		,	2/2	6			$\dashv$			
	souted and transit	xam	Cause (Disease or that initiated events resulting in death) I	linjury s	c. Due to (or as	a concacu	ance off:			3/3				_			
60	hysician and the burial-transit	dical Examiner	resulting in death) t	Last	d.	a consequ	ence on.	_		의 Q 							
876	ng ph as th	Me	F FEMALE:													-	
Division of Vital Records, P.O. Box 687	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent in the past 12 r 1  Yes 20 9  Unknown	months? X No	23c. If yes, outcom  1  Live Birth 4  Pregnant 9  Unknown	2 Fetal at time of d	death 3	Ectopic pregna Other (specify)					23d. Date Mont		ery Day Year		
o	d by t		_		contributing to death	hut not resu	ulting in the ur	nderlying cause	given in Par	† 1	220 Did t	obacco	uco contrib	uto to th	he course of death?	_	
<b>G</b> , 5	signed I be d	d by										'n					
ords	peen	lete	24a. Was an 24b. W									re autopsy findings available					
Secondary Person	te has	Completed									auto perfo	psy	pri	or to co ath?	mpletion of cause of		
al F	rtifica stor, p		25. Was case referre					26.	Place of De	ath (Check		2/14/14	No!	_ res	2 L NO		
Vit	nis ce I direc		examiner? 1XXYes 2	□No	Hospital: 1 ☐ Inpa	tient 2 🗆 I	ER/Outpatien	3 □ DCA O	ther:	Nursing Ho	me 5 🗀 Resi	dence	XX Other	(Specify	Dove House	e	
on of	eath. or: After the	Certificate:	27. Manner of Death 1 Natural 2XXAccident	5 Pending Investigation		ay, Year)	28b. Time of injury 1:50 I		ury at ork? □ Yes 2 <b>X</b>		28d. Describe l Fell Fr		•		Position		
Divisi	s after de	Certi	3 ☐ Suicide 4 ☐ Homicide	6  Could not be determined	28e. Place of In building, e	jury - At hor tc. (Specify) t Home		et, factory, offic	9		28f. Location (9 City or Tov Ha	Street a	and Number te) 1006 tead,	or Rural S MD 2	Route Number, Main St. 21074	====	
Hospi	e Funera	Medical	(Check 2	Medical Exam	rsician: To the best of the basis of self Practioner: To the	examination	and/or investi	gation, in my opi	nion, death o	occurred at	d due to the ca	ause(s) a	and manner ce, and due t	as state o the ca	ed. use(s) and manner stat	ted.	
± 0	To th withir To th	-		title of certifier	10	7 P	W)	29c. Licer	5398			29d. D	Date signed (	Month, i	Day, Year)		
		i [	•		ompleted cause of			int)							, 2011		
(e	Staf		Flavio Kr 31. Date filed (Mont/		D., 555 S	outh (		Street	, West	minst	ter, Ma	ryl	and 2	1157		_	
	Registra		SEP A	8 2011	Sz. negist		fared		-								
DHME	1 17 Rev 7/20	09	U <sub>la</sub> 1			• /											
1						O	RIGINAL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fer FH G919 9/12/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 28612 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1201 A Physician/ Month Q Day assinator Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death 5108 RICHARD AVENUE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 12-17-1936 1 🗆 M 2 🕱 F Hours 74 Yrs. Director 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD BALTIMORE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a o Medical Examiner must be RICHARD AVENUE Funeral 21214 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify Specify: BLACK 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " MEDICAL Elementary/Seconday (0-12) College (1-4 or 5+) NURSE 2 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ROSIE MACON McKINLEY MITH. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau TIMOTHY WASHINGTON RICHARD AVE. BALTIMORE, MD. 21214 SON 5108 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Cemetery, crematory or other place)

ARBUTUS CEMETERY 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/14/11 BALTIMORE, MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERITY SCVS 1. Signature of Funeral Swice Licensee 4905 YORK RUAD. BALTIMORE, MD. 21212 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Smith - Washington Approximate Interval Between Interval Between. Onset and Death Immediate Cause (Final Physician/ Metastatic lung adonocancinoma disease or condition resulting in death) - gear Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Examir attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 9 Unknown Dav Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 1 Yes 2 No 3 Probably 4 Hunknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been is completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Hospital or Attending Physician: The 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 **N**O 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 9-7-11 ▶ Cliarles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles Radgett with, 5601 Loch Raven Blue, Baltimore, wid ziz39 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

1

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5 Per FH C919 9/30/2011 JH
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | | State Registra 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year Month 2,32pm Medical Examiner 4b. City. Town, or Location of Death 4c. County of Death -DCG N/A 249°54×2510 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 74 Yrs. Birthplace (State or Foreign Country) 1 X M 2 □ F 10720736 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Baltimore Examiner must be notified at 10d. Inside City Limits Director N/A MD 1 Yes 2 No 10e. Street and Number 3924 Kimble Rd, 0 105 ZIP 278 10g, Citizen of What Country? 23a Funeral **USA** items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1 Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc.
African
Specify: "natural", or à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed Amer. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) Kennecott College (1-4 or 5+) Room Operator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Scott Inez Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3924 Kimble Rd, Balt., MD 21218 Mamie Scott/Wife 20a. Method of Disposition 20c. Location - City or Town, State
Owings Mills, MD 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 9/12/11 1 Burial 2 Cremation 3 Removal from State Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Pineral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Carcinom Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown signed by the atter in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Be the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pendina 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 3 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boylevard, Baltimore, Maryland 2/218 3900 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

A/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28614 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nancy Starecky Year 201) 1:00 A M September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Seasons Hospice at Northwest Hospital Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours Country) **Director** 187-38-2153 1 M 2 X 64 08/05/1947 Pennsylvania Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Maryland Howard Elkridge 10e. Street and Number rms 23a or ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21075 7377 Cardenview Drive United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ral", or iter Black, White, etc. þ 1X Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural" Specify: 3 Divorced 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the COURCIMENT /NOA +4 Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Menta fitem 27 is marked rother traumatic ev Michael G. Starecky, Sr. Julia Vencius should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heaith ar Important: If item 27 is any injury or other trau Michael G. Starecky - Brother 2808 Porter Street Philadelphia, PA 19145 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 09.07.11 Yeadon, Pennsylvania Sign tur of Funeral Se 22. Name and Address of Facility Dayid J. Weber Funeral Homes P.A. 401 S. Chester Street Paltimore, Maryland 21231 ice Licensee Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Onset and Death Ph.sician/ Metastatic Thy 2010 cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Successful at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year been signed by the a should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has I autopsy performed certificate 2 🗆 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner's 4 Nursing Home 5 Residence 6 Nother (Specify) Partent hospice 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 115 Royapathemio DUUS7465

Registrar

DHMH 17 Rev 06-201:

State

2835.5mith

32. Registrar's Signature

5703

Baloninone

MD 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ray apakse, M.D

DHMH 17 Rev 7/2009

State

Registrar

7601

OSLER DRIVE

-MARYLAND

TOWSON,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAWL

SEP 0 8 2011

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 2011 Robert W. Slaughter 2:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 8. Date of Birth (Month, Day, Year) 1/31/1929 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Hours 135-22-7134 Director 1 X M 2 🗆 F 82 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Florida Palm Coast 1 Yes 2 X No Flager 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Village Circle 32164 U.S.A. ural", or items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. or. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyWhite If Yes, Give "natural", 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) General Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Slaughter Gladys Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. James Slaughter / son 3 Spring Knoll Ct. Lutherville, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Oak Hill Cemetery 9/10/2011 Nyack, New York 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing and Cause (Disease or injury that initiated events -tran Due to (or as a consequence of) resulting in death) Last the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death a 🗌 Unknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page perform 2 No 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **X**No Other: 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 🗌 Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sig 1500

Registrar

DHMH 17 Rev 06-2011

State

Suite 4105.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Claire 2011 A M Springuel 5:00 Alberte August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 8. Date of Birth (Month, Day, Year) April 8, 1929 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🛛 F Hours Belgium Director 577-70-5033 82 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4620 North Park Avenue Apt# 105E 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne-Marie van Nyen Paul Vercruysse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4734 Frederick Avenue, Shady Side, Maryland 20764 Yves Springuel / Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
MONL SOMETY 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State September 7, 4 Donation 5 Other (Specify) Crematorium, Inc. Bethesda, Maryland 2011 21. Signature of Funeral Service Licenses Robert and Advision Few Funeral Home/Bethesda-Chevy Chase, Inc. sel gon, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Streptococcus Viridans Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit Exami Aortic Valve Replacement that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 XNo Month signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Type 2, Hyperlipidemia page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Anemia autopsy this certificate To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, I Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 X Inpatient 2 ER/Outpatient 3 DOA of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge death of 29d. Date signed (Month, Day, Year) D\$\$68160

13 State

Registrar

8/29/11

W

Z

SPRINGUE

DHMH 17 Rev 7/2009

Kimberly B. Zuzak, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Posistrar's Signature

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BERTHA 1220 AM TENSON 04 2011 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** thopica e Northwest Randallstown Baltimore llospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number (In vrs last 8. Date of Birth **Funeral** 213.26.7455 Hours (Month, Day, Year) **Director** 1 M 2 XF 09 23a or 28a-f show st be notified at State 10h County 10d. Inside City Limits 10c. City, Town or Location the Maryland Funeral Director Baltimore 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21215 Reisterstown Road must permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ev Armed Forceş? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1,4 or 5+) Health Care Nurse Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert T. Adams Decle) Armold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 Hendon Road Rundallstown MD 21133 arte Daughte 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place Burial 2 Cremation 3 Removal from State Baltimore, MD 09/09/2011 Arbutus Cemeten 4 Donation 5 Other (Specify) 22. Name and Addr of Facility Jugin C. Greene Funeral Services 21. Signature of Funeral Service License Randallstown MD 21133 Load ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1 Enter th Immediate Cause (Fina disease or condition Physician/ Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Physician/Medical Examine Cause (Disease or injury that initiated events and burlal-tran resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tohacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performe 2 No ☐ Yes Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ,Ce 2 NO ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one the within To the 29h, Sigr 04 201 person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:52 PM September 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 4c. County of Death Examiner Montgomeri Adventi Iak ashinaton oma If Under 9. Birthplace (State or Security Number 8. Date of Birth Month, Day, Yea **Funeral** 1 🗆 M 2 🖼 F Months Hours Country) **Director** December Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 No Falls ( Vilainia 10e Street and Number 10g. Citizen of What Country? items 23a Funeral 2042 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 M Widowed 4 ☐ Divorced Completed Dlack the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Arlinaton HOS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surga မ Johnson noma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowle Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Apprandale, Virginia fleasant Valley Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Fureral 22. N me and Address of Facility China Shirlington Road Arlington Virginia 22206 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Day Month 5 Other (specify) Pregnant at time of death been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖳 No ER/Outpatient 3 DOA မြ Dimpatient 2 this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: Natural Accident 5 Pending work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e 3-11 00060120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 TAITMINA

State Registrar 8

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20I1 Margarita N. Uskievich September 9:31PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) November 19, 1922 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Months Russia Yrs Director 88 212-82-6565 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be with 1 23a Funeral United States 5800 Nicholson Lane Apt. 902 20852 death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Examiner Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify. White Specify "natural" Completed 3X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker 12 Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Nikita Osipov Alexandra Osipova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Richard Uskievich/ Son <u>13329 Foxden Drive, Rockville, Maryland 20850</u> other Baltimore, 20b. Place of Disposition (Name of cemptery, crematory or other place)
Arlington
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State ò October 26, Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2011 | Arlington, Virginia Robert A. Pumphrey Funeral Home/ . 300 West Montgomery Avenue yland 20850-2805 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rockville, Rockville, Inc. Maryl M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Proximal Femur Fracture disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Complications from Left Hip Fracture MO Sequentially list conditions. Examiner Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit Accidental Fall and that initiated events resulting in death) Last Due to (or as a consequence of) as the burial physician Physician/Medical P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Hospital or Attending Physician: The law requires that the death in the past 12 months?

1 Yes 2 No for Month Year Pregnant at time of death Day the a Unknown 9 Unknown ρλ has been signed I je 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Depression Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 🗆 Yes 2 🗆 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: 2 🗆 No မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending ithin 24 hours at er death.

the Funeral Director At properties of the funeral by the funeral part of the funeral by the funeral part of the funer death. August 31, 2011 | 7:00 PM ™ 1 Yes 2 X No Investigation Fall 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5800 Nicholson Lane Apt. 902 Rockville, Maryland determined building, etc. (Specify) At Home Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15-D71517 201 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natalia Vasquez, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 28621 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Nancv M. Wlie August 7:07 a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6831 Alter Street Gwynn Oak Baltimore Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Days Min. Director 213-26-1314 10-28-1914 96 SC Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Tes 2 No Gwynn Oak 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral with 6831 Alter Street 21207 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: African-American "natural", Completed 3 X Widowed 4 Divorced Specify the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4th Danestic Engineer Hanes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Willie Mayfield Ella Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Louella Wylie Garner/Daughter 6831 Alter Street, Gwynn Oak, MD 21207 Method of Disposition Entarbuent 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 9-7-2011 4 Donation Arbutus Memorial Park Other Arbutus, MD 22. Name and Address of Facility Wilie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) State 32. Registrar Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of I	Maryland		artmen tificate			and M		_	201		28	622	
			Registrar  1. Decedent's Name (First, Middle)	e, Last)		Cer	tiricate	OID	reauri		2. Date of De		No. 2 U I	-	3. Time of		
	Physicia Medic	al	Rebeka	h B. Wyat			Sept.						2011	'ear	3:40	A M	
	Examir	er	4a. Facility Name (if not institution	n, give street and number Maris Hospi	•		4b. City,	City, Town, or Location of Death  Timonium				4c. County of Dea			mara		
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. Ia	st birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir	th	9	. Birthpl	more lace (State o	or Foreign	
	Director		216-16-5220	1 □ M 2 <b>X</b> □ F	88	Yrs.	Months	Days	Hours	Min.	Sept.	7. Year 30,	1922	Counti Mar	yland		
	land show dat	ايا	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation							10	0d. Inside Ci	ity Limits	
	larylar 3a-f sl iffied	Director	Md. Ba	ltimore		,		Tou	con							2 X No	
	the M	Ē	10e. Street and Number	TUTIIIOTE			10f. Zip	Tow Code	SUII			10g.	Citizen of Wha	at Count	try?		
	h with ns 23a nust b	Funeral	41 Theo Lane						21204				U'	SA			
	r deat or iten iner r	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Ma</li></ul>	12. Was Deceder Armed Forces	s?	. 13. V	Vas Decedo Yes, speci	ent of His ify Cubar	spanic Orig n, Mexican,	in? (Spe , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Black, 1	America White, e			
21215-0036	safte ral", c Exan		3 XXWidowed 4 ☐ Divorced	If You Give		1	☐ Yes 2	2 💢 No	Specify:				Specify:	Wh	ite		
5-0	2 hour "natu	Completed		nt's Education est grade completed)		16a. Deced	ent's Usua	l Occupa	tion	of workir	na	16b.	. Kind of Busin	nd of Business Industry			
121	thin 7 ene. than	Som	Elementary/Seconday (0-12)	College (1-4 c	or 5+)	life. DO	) NOT use	retired)	Ü		.3		Our	Own Home			
d 2	led wi Hygid other ent, ti	Be (	17. Father's Name (First, Middle,	Last)				пош	emake 18. Mothe		(First, Middle,	Maide Maide		поп	<u>ie</u>	-	
Maryland	d be fi Mental arked Itic ev	유	Leslie	Berryman						Ве	atrice	T	rainor				
lar)	should and h is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rurai	l Route Numbe	r, City	or Town, Stat	e, Zip C	ode)		
ره ر	and 2 Health		Craiganne Baird 20a. Method of Disposition	/Daughter	1001 50	507 V			oad		erville						
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ⚠ Other (	3 Removal from Sta	ate ce	ace of Dispos	atory`or ot	her place			Date 10 / 1 1		Location - Ci	-		د.	
를	mit. P. sartme sortan r injur.		21. Signature of Funeral Service		<u>pura</u>	ney Va					k Tows		monium Funera				
8	Per Deg		muchan	lf Re	ES f	_	050 Yo				son, Ma				-		
9			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that caus only one cause on each I	sed the death line.	. Do not ente	r the mode	of dying	, such as o	cardiac o	r respiratory ar	rest,			Approximat Interval Bet	tween	
7	Physician/ Medical	ii i	Immediate Cause (Final disease or condition resulting in death)	a. CHRONI			E PUI	MON	ARY D	ISEA	SE				Onset and I	Death	
	Examiner			Due to (or a	as a conseque	ence of):											
		Examiner	Figure 1 in the second of the	Due to (or a	as a conseque	ence of):											
	be executed sician and burial-transit	xam	Cause (Disease or iinjury that initiated events	c										$\perp$			
_	certificate be executed nding physician and use as the burial-transi	alE	resulting in death) Last	Due to (or a	as a conseque	ence of):											
209	ate phy the	ledic		d								-					
( 687	certificanding use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Estania a	manono	,				23d. Date of	of delive	ry		
Вох	v requires that the death certific been signed by the attending should be detached for use as	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🌠 No 9 ☐ Unknown	4 ☐ Pregnan 9 ☐ Unknow	t at time of de		Other (spe						Month	1	Day	Year	
0	at the	, Ph	Part II. Other significant condition	ons contributing to death	n but not resu	Iting in the ur	nderlying c	ause give	en in Part I.		23e. Did to	obacco	o use contribu	ite to the	e cause of d	leath?	
s, P.	requires that the been signed by the	γd b									1 🗆	Yes	2 □ No 3	Prob	ably 4 🗆	Unknown	
ord	w requ	Completed									24a. Was				sy findings		
Rec	The law ate has page 2 s	Som									autor perfo	rmed?	? dea	th?	npletion of c 2 $\square$ No	cause or	
tal	sician: The certificate rector, pag		25. Was case referred to medical examiner?	Hospital:		_			ce of Deat	h <i>(Check</i>							
ίζ	Physician: this certific ral director,	2	1  Yes 2  No	1 Inpe	atient 2 🗆 E	R/Outpatien		Other Bc. Injury	4 ∟ Nu		me 5 Resid			Specify)	HOSP:	ICE	
o uc	nding ath. :: After e fune	cate	1 X Natural 5 Pendii 2 Accident Investi	ng (Month, E	Day, Year)	injury	M	work?	res 2 🗆	- 1	28d. Describe h	iow inj	ury occurred				
Division of Vital Records,	r Atte ter dez rector	Certificate:	3 Suicide 6 Could 4 Homicide determ	inod 28e. Place of I	njury - At hon etc. (Specify)	ne, farm, stre	et, factory,	office		:	28f. Location (S			r Rural i	Route Numi	ber;	
ğ	oital o urs af urs af illed in			13.0													
(b)	To the Hospital or Attending Physician: 1 within 24 hours after death.  To the Funeral Director: After this certifica completed filled in by the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director director, the funeral director direct	Medical	(Check 2 Medical I	p Physician: To the best Examiner: On the basis o p Nurse Practioner: To the	f examination	and/or investi	gation, in m	y opinior	n, death oc	curred at	the time, date a	and pla	ce, and due to	the caus	se(s) and ma	anner stated.	
	To the within 2 To the comple		29b. Signature and title of certifie		1 Desir of my	Kilowiedge, d		License	-	апи ріасс	e, and due to th		Date signed (	,			
	)		► ASAIN	WICHNI				KI	497	92			9/6/2	2011	1		
iov			, ,	who completed cause of				,					- <i>1-1-</i> -				
V	Stat	e .	JACKIE JONES, B1. Date filed (Month, Day, Year)		DULAN strar s Signatu		LEY E	<b>.</b>	TIMO	NTUM	, MD 21	1093	3				
	Stat Registra	~		8 2011	en soignate	1. 1	ark	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Ruth Н. Williams 6:45 P M 2011 September 4, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dulaney Valley Assisted Living Hunt Valley Cockeysville Baltimore 9. Birthplace (State or Foreign Country) Maryland . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min Hours 219-12-7313 **Director** 89 12/29/1921 1 M 2 X F ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A. 6638 Walnut Wood Circle iral", or items ! Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural" 3 X Widowed 4 Divorced White Completed of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Raymond A. Harter Mamie Viola Schools 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Murdock Road Baltimore, Maryland 21212 Kirk H. Williams / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any Injury or ott 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp 9/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Year Month Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Ma r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Natural Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

completely

29a. Certifier

(Check 29b. Signature

Date filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month; Day, Year)

910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G919 9/22/2011 JH State of Maryland / Department of Health and Mental Hygiene 28624 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Sepember 1430 pm ma 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Nun**6354** 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min Days 212-10-3<del>654</del> **Director** 1 □ M 2 □XF 92 05/06/1919 MD Usual Residence of Deced 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No BALTIMORE MD OWINGS MILLS ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3440 ASSOCIATED WAY, #307 21117 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐XWidowed 4 ☐ Divorced Specify "natural", WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ည traumatic SAMUEL SILBERMAN **FRAJAH** MARX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 so of Health a item 27 i JANET WOLFSON/DAUGHTER 3 RAINDROP CIRCLE, REISTERSTOWN, MD 21136 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2011 BALTIMORE, MD Signature of Foneral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ jo Dav Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ pe Division of Vital Records, Completed 1 Yes No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 certificate has autopsy death? 2 No 1 Yes Yes the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending death. 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 h

To the Fun

completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28625 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 7:30 AM 09 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Road Gambrills Social Security Number If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In vrs. last birthdav. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 ☐ M 21X (Month, Day, Year) 01/07/1929 Months Days Director 219-30-3471 82 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Gambrills ō 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? Funeral 23a 911 21054 Annapolis Road U.S.A. or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black White etc þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give "natural" Completed 3 Widowed 4 Divorced White Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Prince George's County Secretary Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) ည James L. Maynard Drusilla J. Blakeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Mr. Thomas S. Wolking / husband 911 Annapolis Road, Gambrills, Maryland 21054 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H 1 Burial 2 Cremation 3 Removal from State 9/07/2011 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Obset and Death Immediate Cause (Final Brain Physician Cance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impory) Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) bunialphysician s the burial Medical Division of Vital Records, P.O. Box 68760 attending ph IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined the Hospital Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

Oil

6

11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28626 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Betty M. Wendelstedt 201 5:41 PM Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Square Kustdale 8. Date of Birth
(Month, Day, Year)
May 23, 1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2**X** F Months Hours West Virginia 88 234-32-9203 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2X No Edgemere Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō Funeral items 23a United States 21219 2410 Eugene Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S other traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ō 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: White "natural", Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) Nendels+ed+ 17. Father's Name (First, Middle, Last) Daisy DeMoss မ Lester Shaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 Eugene Ave. Edgemere, Maryland 21219 19a. Informant's Name/Relationship (Type, Print) Henry Clay Wendelstedt(Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment Middle River, MD Holly Hill Mem. Gdns. 9/7/2011 Funeral Service Licensee Buda-Rick Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death DISEASE Immediate Cause (Final EROTT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** YPER TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine DIABETE the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Month Dav Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other} \text{(Specify)} \) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 No ျပ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ser lifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and

31. Date filed (Month, Day, Year)

SEP 08

FRANKLIN SQUARE DR

cress of person who completed cause of teath (Item 23a) (Type, Print)

1105

32. Registrar's Signature

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 2011 9:15 a M Alfred Eugene Wagg, Sr 04Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 200 Bush Chapel Road Aberdeen 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 10/23/1938 Months Maryland 217-36-3205 72 Yrs. Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits the Maryland Ħ 10a. State 10c. City, Town or Location Director or 28a-f sh notified a 1 XYes 2 No Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ural", or items 23a o Examiner must be USA Page 1 and 2 should be filed within 72 hours after death with Funeral 21001 200 Bush Chapel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 Yes 2 XNo Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Landscaping Grass Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wagg Lena Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Wife Fonda Wagg 200 Bush Chapel Rd, Aberdeen, MD 21001 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of h Important: If ite any injury or ot 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 9/8/2011 Harford Mem Gdns. Aberdeen 22. Name and Address of Facility
Tarring-Cargo Funeral Home,
333 S. Parke St, Aberdeen, N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Althorners Dementic yeary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) Hospital: 2 X No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Box 68760

State Registrar

Medical

29a. Certifier

(Check only one

Name and address of person who completed cause of death (Item 23a) (Type, Print) incent 1. 9 minutes, Do 31. Date filed (Month, Day, SEP 0

tle of certifier

2012 Tollgate Rital, Stude 111 Red Air, MD 21015 32. Registrar's Signature

XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

etu054439

29d. Date signed (Month, Day, Year)

September 7, 2011

29c. License number

		1 - For State Registrar		State of Ma	aryland		rtment of F				Reg. No.	11		Time of Death		
Physic	ian	1. Decedent's Name (First Leroy Nath		Wright						Month epton	Day_	3 Jan	n	527 AM		
/Medi Examii		4a. Facility Name (If not in					4b. City, Town, o	r Location of		eh lours	4c. C	County of De				
		Union Memo	orial I	Hospital			Baltim									
Funeral Director		5. Social Security Number 214-30-720	03 10	XV 2□F	76	st birthday) Yrs.	Months Days	If Under 2 Hours	Min. 8. [	Dete of Birth Month Day	7 193	9. Birthplace (State or Foreign 935 Maryland				
and ow		Usual Residence of Dece 10a. State 10b.	County	10c. City, Town or Location									10d. I	Inside City Limits		
Mary Fig.	į	MD i	A\N		E	Balti	more					1 ½ Yes 2 □ No				
th the	lrec	10e. Street and Number					10f. Zip Code				10g. Citizen of What Country?					
ath w	ra	123 29th 8					21218			March No.	U.S	• A • 4. Race - An	adana l	adian		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23e or 28e-f show sing injury or other traumatic event, the Modical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 ★Never Married 2 3 ☐ Widowed 4 ☐ D	2 Married	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	les? If Yes, specify Cuban, Mexican, Puerto  □ No 1 □ Yes 2√2 No Specify:					resorno- in, etc.)		Black, Wh	llack, White, etc.			
72 hc	eted	15. D (Specify onl)	Decedent's Educ ly highest grade	ation completed)		16a. Deced (Give	ent's Usual Occup kind of work done OO NOT use retired	ation during most	of working		16b. Kin	d of Busines	s/Industr	У		
within sne.	Completed	Elementary/Secondary 7th Grade	(0-12)	College (1-4or 5	+)		orer	a)			Car	Wasl	n			
Hygie	0	17. Father's Name (First,	Middle, Last)				0101	18. Mother	r's Name (Fi	rst, Middle,	Maiden S	Sumame)				
lid be fental rked c	ToB	Richard W:	illiam	S				Ali	ce Wr	ight						
and N		19a. Informant's Name/R	lelationship (Typ	oe, Print)			g Address (Street									
and and m 27		Mildred Ra		(sister	)		Retrea					MD .				
Pages 1 ment of H lant: if Ite		20a. Method of Dispositio 1 ☑ Burial 2 ☐ Crea 1 ☐ Donation 5 ☐ 0	mation 3 R		Mt.	Zion	sition (Name of natory or other place of Cemete	ery 0		11	Balt	imor	e, M	MD		
permit Depart import eny in		21. Signature of Funeral	tich	N.W.		1021	osephod 40 N. I	ulto	n Ave	., B	aiti	al H	, MD	21211		
icate be executed  Wedical  Whysician and  physician and  whe buriat-transit	dical Examiner												erval Between set and Death			
Attending Physician: The law requires that the death certific redath.  ector: After this certificate has been signed by the attending is by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregiin the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nami	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal c	death 3□	Ectopic pregnanc	у			2	3d. Date of o	lelivery Day	y Year		
s that	by P	Part It. Other significant	conditions con	tributing to death bu	ut not result	ting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco us	se contribute	to the ca	ause of death?		
w require been sig										10,	Yes 2	No 3□	Probably	4 □Unknown		
The law of the law of the has be page 2 sh	Completed								_	24a. Was autor perfo 1 ☐ Yes		prior t death	o comple	findings available etion of cause of No		
clan: sertific actor,	Be	25. Was case referred to examiner?	_	e en itali			O#		of Death (C	heck only o	ne)					
Physic this of	2	1 ☐ Yes 2 No 27. Manner of Death		ospital: 1 ☐ Inpatie 28a. Date of Injur		R/Outpatien 28b. Time of	t 32 DOA		rsing Home	5 Resident		-	oecify)			
ding h. After funer	to Lo		Pending investigation	(Month, Day	Year)	Injury	28c. Injui Wo	rk?  Yes 2 □ 1		. Boombo						
or Attending Physician: The lavariate death. Director: After this certificate has din by the funeral director, page 2	Certification:		Could not be determined	28e. Place of Injubuilding, etc	ury - At hon c. (Specify)	ne, farm, str	eet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Medical C			ician: To the best of ner: On the basis of and manner sta	examination											
To the withir To the Comp	M	29b. Signature and title of	f certifier	5			29c. Licens	se number	73	1		signed (Mo		, Year) 2011		
V		30. Name and address of	201 F	nes Duine	بالدسا	Dhin	T2. 11		MID	2121	8					
St.	ate	Yaul Kars 31. Date filed (Month, Da	y, Year)	32. Registra	ar's Signati	eni	A LAM	nue	7-(17		-					
Regist		SEP 0	8 2011	32. Registra	B. 1	gare										

DRIMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4b. City, Town, or Location of Death **Examiner** Howard county Columbia If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, ) Days Year 1923 1 M 2 X F Months Hours Min. Country) 88 SC Director 093-28-7327 Mar Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 10773 McGregor Dr. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: Completed 3 Nidowed 4 Divorced **Black** Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Switchboard Operator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Jesse McCree Katie McCree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20017 1319 Allison St. NE Tracy Young - Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Columbia Memorial Park 9-7-2011 Columbia, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Marshard Marchity Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence Exami the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a conseque resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cer 0 gr Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2011 Physician/ Eileen Cary Anderson August :10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2738 Moran Drive Charles Waldorf 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Country) 1 M 2 X F Months 56 Yrs 213 66 0187 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director notified 1 XYes 2 No MD Charles Waldorf 10e Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral 2738 Moran Drive 20601 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black White etc. þ 1 Never Married 2 Married 2 XNo within 72 hours after Yes Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exar 3 Widowed 4K Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Frame Attendant C&P Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Arthur Anderson Anna Southerland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Millar/ Son Moran Dr. Waldorf. MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 8/26/2011 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd, Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Who
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death i signed by the aid be detached if detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: Other: ည 1 Yes 2 X No ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suícide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖳 🥰 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State

RB4

Registrar

31. Date filed (Mont)

Registrar's Signature

was

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 M Anthony NMT Amoddio Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Dec 22 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months New Jersey 143-18-6138 Director Dec. 1923 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 978 A Saint Clair St. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Tool Grinder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Amoddio Mary Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Amoddio/Daughter 10348 Old Frederick Rd., Woodstock, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 Burial 2 X Cremation 3 Removal from State Smithsburg, MD 4 Donation 5 Other (Specify) Smithsburg Crematory 8/19/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania ave., Hagerstown, 23a. Part 1. Enter the disease, or complicat that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Renal Physician/ hvoni 6 Discase disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DISECSE oroman Sequentially list non-ditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Diabet attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Tinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day. Year) 060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opal 4 MURSHED ARID 21740 31. Date filed (Month, Day, AUG egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20

			State Registrar	C	ertifica	te of D	eath		R	eg. No.				
	HH.		1. Decedent's Name (First, Middle, Last)		2. Date of I Month									
	Physicia Medic		Linda Eleanor Allnutt						August	18, 20	11	8:54A M		
المراعوية	Examin		4a. Facility Name (if not institution, give street and number)		4b. Cit	4b. City, Town, or Location of Death				4c. Count	y of Death			
ار			Hospice House	Ca1	Callaway				St.	Mary'	s			
	Funeral		5. Social Security Number 6. Sex 7. Age (In		er 1 Year	if Under		8. Date of Birth		9. Birthp	lace (State or Foreign			
	Director		215-36-4319   1   M 2   K   8	9 Yrs	. Months	Months Days Hours Min. (Month, I					Mary	yland		
	*		Usual Residence of Decedent											
	and sho	Ö		c. City, Town or							1	0d. Inside City Limits		
	faryl Ba-f tifie	Director	Md. St. Mary's	Saint	: Inig	oes				1 🗷 Yes 2 □ No				
	or 2	吉	10e. Street and Number		10f. Z	ip Code				10g. Citizen of What Country?				
	with 1	iral	18171 Stokes Drive				2068	34		United States				
	ems r mu	Funeral	11. Marital Status 12. Was Decedent Ever	in U.S.	3. Was Dec	edent of His	spanic Ori	gin? (Spe	cify Yes or No-	14. Race - American Indian,				
0	or it	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No			ecify Cubar			rican, etc.)		ack, White, e			
3	saft ral", Exau	귷	3   ✓ Widowed 4   □ Divorced  If Yes, Give Year or Dates.		1 ∐ Yes	2 🔀 No	Specify:			Specif	y: Whi	te		
Ş	hour natu lical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Us live kind of w	sual Occupa	ation	t of worki	na	16b, Kind of I	3usiness Inc	dustry		
Ĭ	n 72 an " Med	Ĕ	Elementary/Seconday (0-12) College (1-4 or 5+)	life	e. DO NOT u	ise retired)		E OF FROM	19		77			
77	withi giene er th , the		12 0		Hom	emake	r				wn Ho	me		
ğ	filed all Hy loth	Be	17. Father's Name (First, Middle, Last)					_	(First, Middle, M		ne)			
<u>a</u>	Aentz Aentz Irkec tic e	၉	Herman Walker				<u></u>	ula	Thompso	n				
Maryland 21215-0036	hould and N s me	- 1	19a. Informant's Name/Relationship (Type, Print)							City or Town, State, Zip Code)				
Σ	d 2 salth alth 27 i		Robert E. Allnutt / Son	181	l71 St	okes	Drive	e, Sa	int Ini	goes,	Md. 20	0684		
ā.	1 and of He item		200	20b. Place of D	isposition (N		۵)		Date	20c. Location	- City or To	own, State		
Ë	bage lent c nt: If ny or		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Mt. Tab				8/22	2/2011	Etchi	son, 1	Maryland		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Inportment of Health and Mertal Hygiene. Inportment of Health and Mertal Hygiene are any injury or items Z3 a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22 Namo	and Address	s of Facili	tv		TT				
ñ	Imp per any	- 7	Roy (). Barber	4	Muri	el H.	Bari × 50	ber b 38. I	uneral avtonsv	ноте ille.	Md. 20	0882		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira										est,	15	Approximate		
	to taken/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Atheros	cleroti	ic Car	diova	scu1a	ar Di	sease			Interval Between Onset and Death 10 years		
	h_i_ian/ Medical	i i	disease or condition resulting in death)  a.  Due to (or as a co									10 years		
	Examiner		Due to for as a co	onsequence on.										
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a co	onsequence of):										
	ed sit	Ξ	cause. Enter Underlying Cause (Disease or iinjury											
	executed an and rial-transi	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a co	onsequence of):										
	cate be executed physician and the burial-transit	Medical	d											
8760	rificate be ing physici as the bur	edi												
88	erifi Iding Ise as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	oregnancy						23d. [	Date of deliv	ery		
BOX	death ce	Physician	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 1 Pregnant at til		3 ☐ Ectop 5 ☐ Other	ic pregnand (specify)	у			V	/lonth	Day Year		
	the deched	ysi	9 Unknown											
P.O.	nat the	F P	Part II. Other significant conditions contributing to death but	not resulting in t	the underlyin	ng cause giv	en in Part	I.	23e. Did to	bacco use co	ntribute to t	he cause of death?		
	sign d be	d by							1 🗆 🗎	∕es 2 🛭 No	3 🔲 Pro	bably 4 🗌 Unknown		
ğ	law requires that the death cer iffor nas been signed by the at ending p e 2 should be detached for use as	Completed							24a. Was a	an 24k	. Were auto	psy findings available		
) လ	lav las	ם		***					autop	sy med?	death?	empletion of cause of		
ř	: The cate ; pag								1 🗆 Yes	2 X No	1 Yes	2 □ No		
ta	ician sertif ecto	Be	25. Was case referred to medical examiner?			LOth			k only one)	1		Hospice		
>	Phys this al dir	은 ::	1 ☐ Yes 2 🕅 No ☐ Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outp		DOA   28c. Injur	4 L N	lursing Ho	ome 5 Resid			у) Поврасо		
0	ling I After funer	ate	1   Natural 5 □ Pending (Month, Day, Y			work	Yes 2	¬ No I	200. Describe ii	ow injury occu	ii ca			
<u>Ö</u>	tenc death tor:	≝	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home farm			103 2 2	110	28f Location /S	(Street and Number or Rural Route Number,				
Division of Vital Records,	I or Attending Physician: The law after death. Laster death. Director: After this certificate has in by the funeral director, page 2 in by the funeral director, page 2.	Certificate:	4 Homicide determined building, etc. (	Specify)	i, atreet, raci	ory, omoc			City or Tow		20, 0, 113,4			
	pital ours eral [		29a. Certifier 1 Certifying Physician: To the best of my	knowledge de	ath occured	at the time	date and	l place ar	nd due to the car	use(s) and mai	nner as stat	ed.		
	To the Hospital or Attending Physician: The within 42 hours after death.  To the Funeral Director: After this certificate is completed filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: On the basis of examiner)	nination and/or i	nvestigation.	in my opinio	on, death o	occurred a	t the time, date a	nd place, and (	due to the ca	ause(s) and manner stated.		
	o the ithin o the omple	Σ	29b. Signature and title of certifier			29c. License		o una pia		29d. Date sign				
	ĕ≱ĕŏ		1 Will Sille	5		1	003	31563				3, 2011		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	\		Charles M. Benner, M.D.	20945 G	reat 1	M <b>i</b> lls	Road	1, #2	03, Lex	ington	Park	, Md 20653		
	Sta	e	31. Date filed (Month, Day, Year) 32. registrar's		-									
	Pegietr		ALIC 9 2 2011 /2 march	0.	back	Barrier .								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 28633 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2011 Year Physician 5:45a 08 29 John Edward Albright /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Frostburg 16707 Loartown Rd SW If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**M 2□ F 90 215-18-8762 11-05 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Worldest Even in the top of the of 1 ☐ Yes 2 No Frostburg Director MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21532 16707 Loartown Rd SW Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Armed Forces?
1 Armed Forces?
1 Armed Forces?
1 Armed Forces?
1 Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Specify: þ White 3 Widowed 4 □ Divorced Year or Dates: 1945 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Item Many injury or other traumatic event in the Many injury or other traumatic event College (1-4or 5+) Elementary/Secondary (0-12) Railroad Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Albright Loar Patrick Edward Shertzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Shoemake daughter MD 21532 104 Maple Terrace Frostburg, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08-31-2011 Frostburg, MD Frostburg Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sowers Funeral Home, P.A. 60 W. Main St., Frostburg, MD 21532 MO0547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the ode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ne sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 ☐ Unknown 2 🗌 No 1 ☐ Yes certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 2 🗆 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1∐ Yes 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manne Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar Name and address of person will

0 8 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aug 21, 2011 Ralph 2:00 P M H. Bovd Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 10160 Old Indian Head Road Upper Marlboro Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ 83 184 20 3119 Director Nov 29. Usual Residence of Decedent show 10b. County at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 28a-f Examiner must be notified 1 Tes 2 TYNo Maryland 1 4 1 Prince George's Upper Marlboro o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 10160 Old Indian Head Road 20772 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 6 1 Tyl Yes 2 No
If Yes, Give 1946-1947
Year or Dates 1946-1947 þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify. "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sporting Technicians Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Huga Boyd unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Magdalena Boyd (Wife) 10160 Old Indian Head Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 M Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-25-2011 Cheltenham, MD Lee Funeral Home Crematory Signature of Funer | Sewice Line 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria m00251 Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) ration. Sequentially list conditions, as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director. 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Hospital Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Configure Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur of certifier 00053277 who completed cause of death (Item 23a) (Type, Print) Name and addr

Registrar

State

31. Date filed (Month, Day

AUG 2

NBIT!

1525

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 18<sup>ay</sup> 9:50 PM 2011 Allie May Moxley Buxton August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Damascus 28001 Ridge Road 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Year) Sept. 1, Days Hours 1 □ M 2 🕅 F Months Maryland 93 1917 213-38-3399 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 🗌 Yes 2 🗶 No Maryland Damascus Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20872 28001 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify. White 3 🕅 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maud Hurley Arville Mox1ey Alvie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28001 Ridge Road, Damascus, Maryland Stephen A. Buxton - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State Montgomery Methodist | Aug. 24, 2011 Damascus, Maryland enation 5 Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland Signature of Foneral Service Licen 20872 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final HYPENTENSIUZ CERBANAL UPSCULAR DISGASE disease or condition resulting in death) Due to (or as a consequence of) Due to for as a consequence of Due to (or as a consequence of)

Physician/ Medical Examiner

for use as the burial-transi

and

the attending physician

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached.

death.

o 24 hours after deat Funeral Director:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Director

Funeral

þ

Completed

Be

ည

Examine

Physician/Medical

Completed by

Be

Certificate: To

Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

examiner?

4 Homicide

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Pregnant at time of death 9 Unknown

3 Ectopic pregnancy
5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

August 19, 2011

24a. Was an autopsy performed? Yes 2 2 No 1 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 1 🗓 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

D26499

29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 🗌 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#4 Culwell Drive, Mount Airy, Maryland Ronald E. Miller, M.D

State Registrar

3

32, Registrar's Signatur 31. Date filed (Month -record

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28636 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ AUG.30, 2011 Year EVELYN POWELL BRIDGETT 6:15A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death ABBEY MANOR ASST.LIVING LA PLATA CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) VA • 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 24 Min 1 🗆 M 2 🖵 F 578-24-0104 **Director** 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ler must be notified MD. CHARLES WALDORF 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4065 OLD WASHINGTON ROAD 20602 U.S.A. should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ PRIBBLE HOUSTON POWELL HAZEL MARGARET WOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELBY BOWLES-EXECUTOR 11855 HOLLY LANE WALDORF, MD. 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS 9-2-11 WALDORF, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HIND SCLORD SIT disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events ONGESTEVER Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

· Sur State

Registrar

ras 12 31. Date filed (Month, Day, Year)

and address of person

29b. Signature and title of certifier

only one)

ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:00AM ARA ANN BROWNBACK Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** MECIL R151NG 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💢 F Months Director ENN Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death when the Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene, Important: If them 27 is marked other than "natural", or items 23a or 28a-f show Important: If them 27 is marked other than "natural", or items 25a or 28a-f show Important: If the Important is must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CECIL 2151NG-5UN 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 711 E. MAPLE HEIGHTS 19 .5. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No ģ 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 No Specify: WhITE 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 40 MEMATER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LECKNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COUNTRY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Mc 224 PENN AND CXFORD, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No hours after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and til 29d. Date signed (Month, Day, Year) 2011 D0062190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 SHAHNAUAZ

31. Date filed (Month, Day, Year)

SEP 0 8 2011

KHAN

32. Registrar's Signature

Baltimore.

Box 68760

P.O.

Division of Vital Records,

, 2533 AUGUSTINE HERMAN HWY, SUITE A, CHESAPEAKECITY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22, AUGUST Physician/ 2011 9:00 A M AUDREY CECELIA BUTLER CUTCHEMBER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES INDIAN HEAD RESIDENCE. 3485 MEDWAY STREET g. Birthplace (State or Foreign Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Hours MARYLAND DECEMBER 27.1944 Yrs 213-44-3927 66 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director items 23a or 28a-f s her must be notified 1 ☐ Yes 2X No INDIAN HEAD MARYLAND CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES Funeral 20640 3485 MEDWAY STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ŏ by 1 Never Married 2 Married 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 If Yes Give Specify: BLACK "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene FEDERAL GOVERNMENT PAYROLL SUPERVISOR 12TH GRADE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H. Important: If item 27 is marked any injury or cert. MARY HICKS BUTLER JOSEPH BUTLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3485 MEDWAY STREET, INDIAN HEAD, MARYLAND 20640 SHARON CUTCHEMBER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State TRINITY MEMORIAL GARDENS AUGUST 29,2011 WALDORF, MARYLAND 4 Donation 5 Other (Specify) Strature of Funeral Sovice Lic 1999 THORNTON FUNERAL HOME, P.A. TNDTAN HEAD, MARYLAND 20640 THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between iset and Death Mon-fhs 2<sup>Ons</sup> Immediate Cause (Final Pnysician/ Cancer of the wrethra disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? 1 Yes 2 No eral Director: After this certificate I 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 1 Tyes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ∐ Yes 28d. Describe how injury occurred 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

NB5

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHOLAS DE MONACO, M.D.

AUG 2

31. Date filed (Month, Day

29c. License number 064234

8926 WOODYARD ROAD, SUITE 201, CLINTON, MARYLAND 20735

AUGUST 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State 28639 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN PENDLETON CURTIS AUG. 27, 2011 Year 2330 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST.MARY'S HOSPICE HOUSE ST.MARY'S CALLAWAY Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🔀 M 2 🗆 F Months Hours Min. VA. 1Mpnth 27 - 1929 579-34-2249 81 Yrs. Director Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD. CHARLES INDIAN HEAD 1 🗆 Yes 💥 No 10e, Street and Number ms 23a or must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 5485 PORT TOBACCO ROAD 20640 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

X Yes 2 No Black, White, etc. ARMY ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural" Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GREYHOUND BUS LINES BAGGAGE CLERK 8th Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOHN M. CURTIS NORA GAY FRAZIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALDEAN CURTIS-SPOUSE 5485 PORT TOBACCO RD. INDIAN HEAD, MD. 20640 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HICAMUXEN METH CEM 9 - 3 - 11CHICAMUXEN, MD. permit. Signature of uneral Service Licensee M00479 RAYMOND FUNERAL S LA PLATA, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown cate has t een signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I perform 2 🗆 No Yes 2 1 Tes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 X No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? Accident

Suicide

Homicide 2 | No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1/ ou

State Registrar 31. Date filed (Month, Day, Year)

8 2011

consend town

of person who completed cause of death (Item 23a) (Type, Print)

-27-2011

20650

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend I tem 25 per med cert 6921 II / 16/II dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 28640 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Hushel Elsworth Davis 22 :40 Medical August 4a. Facility Name (if not institution, give street and number)
Prince George's Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Cheverly Social Security Number 8. Date of Birth (Month, Day, May 11, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
74 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Min. 578-52-0231 1 🕅 M 2 □ F Days Hours Day, Washington, DC Director Usual Residence of Deceden 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f District of Columbia Washington 1X Yes 2 No 10e. Street and Number ms 23a or must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 5350 Call Place, SE Apt. 14 20019 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status the Medical Examiner Armed Forces? ò 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: American If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. 12 years Postal Worker Government permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hushel Davis Mary Poles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Davis - Brother 3159 Gela Road Oxford, North Carolina 27565 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Heritage Mem. Cemeterly Aug 29, 2011 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Fatal awythmi
Due to (or as a consequence or: disease or condition resulting in death) Medical Examiner Periccirdia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the derivation that the purial Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Pregnant at time of death Day 4 Pregnant 9 Unknown 9 Unknow After this certificate has been signed by interest director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending death. Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the ⊒ Acciden ⊒ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical (Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d, Date signed (Month, Day, Year) ٥ 5522 completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 28641 State Registrar Amend#2pfh8/29/2011ccdohrb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:15 P Lucille M. Davis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Nursing Home Prince George's Clinton 1 4 1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 TF Days Hours 213 42 9489 Mary land Director 89 May 8 Usual Residence of Decedent 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Clinton 1 🗆 Yes XX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 11417 Tippett Road 20735 United States permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Yes 2 XX Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8th Domestic Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Davis Helen Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandi M. Miller (Friend/POA) 11417 Tippett Road, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 29, 2011 Resurrection Cemetery Clinton, MD 21. Signa ure of Funeral Sen 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death Month Year Day ed by the a 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 Dishetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier မ 29d. Date signed (Month. Dav. Year) D0052999 alremas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 10403 Hospital Drive G-06 CLINTON MD20735 RAHIMIAN MD 31. Date filed (Month, Day, Year) 32. Regištrar's Signature State AUG 24 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	-		irtment of F tificate of L		d Mental	Hygier Reg. I	20		28642	
Physic	1. Decedent's Name (First, Middle, Last)  Physician/ Modical  Elizabeth Lee DARROW  2. Date of Death  A Month Day  A UOU ST 2 20											3. Time of Death	
Med	Medical Examiner  Elizabeth Lee DARROW  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death										of Death	3:08 PM	
LAdili	illei	Meritus Medical				Hagerstown				Washington			
Funera Directo	_	5. Social Security Number 054–28–2455	. Sex 7. Age 1 ☐ M 2 🗓 F	(In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N		of Birth th, Day, Year	932	9. Birth Cour <b>Nev</b>	place (State or Foreign htry) Jersey	
id now	٦٠	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	orloc	ation						10d. Inside City Limits	
farylar 3a-f sh iffied	Director	Maryland Washir	acton	,		town						1 🏿 Yes 2 □ No	
a or 28	Ē	10e. Street and Number	igton į	Hag	CIP	10f. Zip Code			10g.	Citizen of V	Vhat Cou	ntry?	
th with ms 23a must	Funeral	624 Observatory			1	<u> </u>	21742			_	SA		
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced	ver in U.S. No	If	/as Decedent of Hi Yes, specify Cuba	n, Mexican, Pu		k, White,					
215-0036 in 72 hours after e. han "natural", o Medical Exam	Completed	15. Decedent' (Specify only highest	Year or Dates.  s Education grade completed)	16a.		ent's Usual Occup ind of work done o		workina	16b	. Kind of Bu	usiness In	dustry	
rithin 72 ene.	Som	Elementary/Seconday (0-12)	College (1-4 or 5-		life. DC	NOT use retired) maker	aring moor or	g		Her	OWD	home	
filed will Hygin I other vent, t	Be	17. Father's Name (First, Middle, Las		1	Още	maker	18. Mother's	Name (First, M	fiddle, Maide			nome	
ylar	2	Call Faul Callson									mes		
Maryland 2 should be filed th and Mental Hy 27 is marked off traumatic event		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  624 Observatory Drive, Hagerstown, Md											
Te, land the Healt item 2		20a. Method of Disposition	- Husband	20b. Place of	Dispos	sition (Name of		Date		Location -			
		1 ☐ Burlal 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State ecify)			atory or other place n Cremat		23/2011	Hag	gerst	own,	Maryland	
Baltimo permit. Page Department of Important; If any injury or		21. Signature of Funeral Service Lic	ense		22.	Name and Addres	s of Facility	Minni	ch Fu				
		23a. Parv. Enter the disease, or co	opplications that caused	the death Do n		15 E. Wi				own,	Ma.	Z1/4U Approximate	
-Ph. sician		shock, or heart failure. List onl Immediate Cause (Final		Interval Between Onset and Death									
Medica	1	disease or condition resulting in death)	a. Due to (or as a	consequence o	f):						$\dashv$	are weet	
Examine		Sequentially list conditions,	b. Reet		(e (	Disco	ise					cere month	
ed	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Date to (or as a	Line to (5) as a nonsequence off:									
execut in and ial-tran	Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequence o	f):						$\neg$		
f <b>bU</b> cate be executed physician and the burial-transit	edical		d										
66/ ertifica iding p	/We	IF FEMALE:	23c. If yes, outcome of	of pregnancy						00.1.0			
<b>BOX</b> e death c the atten	Physician/M	23b. Was decedent pregnant in the past 12 menths?  1  Yes 2 No 9 Unknown	1 Live Birth 2	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Mont								Day Year	
that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions.									ibute to t	he cause of death?	
dS, quires en sign	ed b	Atrice tibe	illation					_	1 🗆 Yes	2 🗌 No	3 🗌 Pro	bably 4 Unknown	
Hecords,  The law requires ate has been sig	Completed	A wte Ren	I Fales	e				24a	. Was an autopsy	l t	orior to co	psy findings available empletion of cause of	
The It Th								1 [	performed' Yes 2		death?	2 🗆 No	
VICAL ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	nt 2 🗆 ER/Qu	h	Oth	er.	Check only one		↑ □ 011	10		
OT Ng Phy ter this neral d	te: To	27. Manner of Death	28a. Date of injur (Month, Day,	y 28b. T		28c. Injury work	at at	ng Home 5 28d. Desc	cribe how in			/)	
tendir leath. tor: Aff	Certificate:	Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion			M 1 □	Yes 2 No						
DIVISION tal or Attendin s after death. I Director: After ed in by the fur		4 Homicide determine		ry - At home, far (Specify)	m, stre	et, factory, office			Location (Street and Number or Rural Route Number, City or Town, State)				
LIVISION OF VITAL RECORDS, P.O. BOX 05/17 to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exa	hysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination and/or	r investi	gation, in my opinic	n, death occur	red at the time,	date and pla	ace, and due	e to the ca	iuse(s) and manner stated.	
To t To th		29b. Signature and title of certifier				29c. License				Date signed		Day, Year)	
		20 Nome and address of acres	-guil)	eath (Itary 00-) m	June C		5760	00		3/22	111		
JN-7		30. Name and address of person where Gui) Calla	completed cause of de	L Jel	ype, Pr	son BIVB	-5m	mra	I MI	D 21	73	3	
St Regist	ate rar	31. Date filed (Month, Day Year)	2011 32. Registral		A	Sarl							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ust 17, 2011 Physician/ Betty Jane Davis Medical 4a. Facility Name (Onot institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Meritus Medical Center MD Caretown. Washington Country 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Mary Land 216-22-8700 2 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location Director 1 Yes 2 No Maryland Washington County Cavetown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22501 Cavetown Church Road 21720 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bus Contract Owner Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္က Unknown Viola Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki L. Green/ Daughter 13433 Kretsinger Road, Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 N Cremation 3 Removal from State Smithsburg Crematory August 21,2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North. Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due till ras a consequence of): disease or condition resulting in death) Medical Examiner 30 minules condiac disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to for as a consequence of) Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 4 Pregnant Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Rench insufficience 2 No 3 Probably 4 Unknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypothypaidism autopsy perform death? a 1 🗌 Yes 2 🗆 No Mentis Medical 25. Was case referred to medical examiner? Center funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 No 2 1 Inpatient 2 INFR/Outpatient 3 IDOA After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? ■ Natural injury 5 Pending Investigation Accident 24 hours after death Funeral Director: completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one the 29d. Date signed (Month, Day, Year) 0 D0071052

DHMH 17 Rev 7/2009

State Registrar Susanno M

Smithsburg

eted cause of death (Item 23a) (Type, Print)

22911

Coheen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06508 State of Maryland / Department of Health and Mental Hygiene Richard William Downey 28644 1- For State Certificate of Death Reg. No Registrar 3. 0608 Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 29, 2011 **Medical Examiner** RICHARD WILLIAM DOWNEY 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Queen Anne's Queenstown Queen Anne's Emergency Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreignWASHINGTON Country) DC Days Hours Months Director MAR.19,1981 213-98-1775 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Iny 10a, State 10b. County 1 Yes 2 X No 28a-f show GRASONVILLE QUEEN ANNE'S Baltimore, MD 21215-0036

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a nr 23a-f sho injury or of the remainteer was the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21638 106 FOX RUN 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes WHITE 1 Yes 2 X No specify: Specify: 3 Widowed If Yes Give Year 4 Divorced ゑ 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION MATERIALS OPERATIONS MANAGER -0-12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FAYE ELLEN THOMPSON JOHN FRANCIS DOWNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 304 FOX RUN, GRASONVILLE, MD 21638 FAYE ELLEN DOWNEY/MOTHER 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State SEPT.3, STEVENSVILLE CEMETERY STEVENSVILLE, MD 2011 Donation 5 Other Specify 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval 232 Part I. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Wedical Death aAlcohol and Oxycodone Intoxication complicated by cocaine us Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g919 9-9-11 sm 3 per me g919 9-26-11 vt attending physician or use as the burial -X UNPENDED Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 2 Fetal death 3 Ectopic pregnancy Month Day Live birth for use as past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown icate has been signed by the page 2 should be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 2 No 1 🗸 Yes certificate 25 Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 COA Other: Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification Natural Unknown 1 1 Yes 2 X No Pending fd 8-29-11 fd 5:20 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)  $106\ Fox\ Run$  Grasonville, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital ar Attending Physician: hours after death.

uneral Director: A 24

> 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) August 29, 2011

1Asse

and manner stated

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrat's Signature

31. Date filed (Month, Day Year State Registra

DHMH 17 Rev 1/2001

**OCME 2006** 

one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Nicholas Joseph Dormio Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M M 2 □ F 07-19-1937 Months Hours Mary Land 74 219-34-6076 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Funeral Director 1 Yes 2 No LaVale Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 549 National Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 19
If Yes, Give 10 14. Race - American Indian 11. Marital Status Black, White, etc. 1958 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 1962 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 5 College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Holtz Dormio Joseph Dormio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 549 National Highway LaVale, MD 21502 Diane Dormio wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Cumberland, MD Cumberland Crematory 08-29-2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Sowers Funeral Home, P.A. in Frostburg, MD 21532 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AGIOCARCINOMA Immediate Cause (Final METASTATIC Physician, disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown certificate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 🗷 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛮 No ER/Outpatient 3 DOA 1 Yes 1 Inpatient 2 I မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 🗹 Natural 5 Pending Accident
Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M 0 rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

filed (Month, Day, Year)

SEP 0 8 2011

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28646 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nehowen 80 0430AM Medical NOS 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Julia Manoa Here th Case Haberston Washington Social Security Number **Funeral** If Under 1 Year | If Linder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year) 1927 1 🛛 M 2 🗆 F 83 Hours 0ct. 13 Vi~~nia Director 226-30-8921 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at Washington 10c. City, Town or Location Hagers town 10a State death with the Maryland 10d. Inside City Limits Director 1 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 836 Marion St. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Year or Dates. 46-47 White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Ind. Saleman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mamie Mosee ၉ Hayes E. DeHaven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Surrey Ave. Apt. 1H Hagerstown, Md. 21742 Carol Kathleen Mertz(Daughter) Date 30. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Smithsburg Crematory Smithsburg,Md. Signature of Funeral Service Licen: 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ End Stave Vascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? signed by the atte Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ anicer, Dysphabia, Psychotic Major Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Depression, Anemia of Chronic Diseases 24a. Was an has page 2 s within 24 hours after death.

To the Funeral Director: After this certificate becompleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number who completed cause of death (Item 23a) (Type, Print) 333 Mill Stracet, Huberistowy, MD 21740 CANP-Barbaro-Naden 31. Date-fileti (Month, bel), weir

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28647 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date C. Month Physician/ 1727 ELLEN LOUISE **EDWARDS** Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 542156414 VICOMICO REGIONAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 4 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 1944 **Director** 214-42-8008 67 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Kent Chestertown 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 U.S.A. 130 Clipper Way 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify White 3 🗌 Widowed 4 🙀 Divorced Specify: Completed al Hygiene. d other than "natura" event, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Glenn M. Turner Velma Gears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (brother) 10636 Worton Rd. Worton, MD. 21678 Glenn Turner 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗆 Burial 2 🔀 Cremation 3 🗔 Removal from State 8/30/11 Kent Cremation Service Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 M00510 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Ph\_sician/ Malhsysty 80 Ca disease or contrion resulting in Medical Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Exami -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Non Dod 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown Be Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 24 hours after death.

Puneral Director After this certificate has become a director, page 2 ? autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) ٥ 1 🗆 Yes 2 🐼 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the P only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUMOLG - 29.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMUSTER 106 MILLIEN 21804 Choreen C54711

EHMM 17 Roy 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

SEP 0 8 2011

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav 8 4140PM enneth Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Wishington

9. Birthplace (State or Foreign 1-kgerstou man 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days June 16 1 X M 2 🗆 F Hours Min. Maryland 1939 Director 219-36-4606 Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1X Yes 2 ☐ No Maryland Hagerstown Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Nottingham Road 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Door Manufacturer 0 Sheet Metal Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Fred Feigley Ruby Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham Road, Hagerstown, Md. 21740 Teresa A. Feigley - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 8/22/2011 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home of Funeral Service License 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleret disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hear Cause (Disease or iinium Diastolic that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE es, outcome of pregnancy

Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation, Ventricular tachycardic 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death?
1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending iniury Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

JW-6

Registrar

Barbar

a

- Dlucher, CRNP -333 Mill Street, Haverstown, MD 21740 Naden 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28649 Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UELINA emilia 2019 1:34 DM Medical 4a. Facility Name (it not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 905 Keswick rarles Shite SINS Age (In yrs. last birthday) If Under 1 Yea 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -54-1 M 2 XF Months Days Hours Min Sashington Director DO Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director 1 Ves 2 No Qe. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ecith care JURSE Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ Mam 19a. Informant's Name/Relationship (Type, Print) aushter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2067 reek Dr ACCO Keek MD Department of Healt Important: If item 2 any injury or other t BRING 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Borial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 엉 Upper lugiciboro, MD Funeral Service 22. Name and Address of Facility WISCHICA FUNCTOR 21. Signature Hexandrus Ferry read Clinton 527 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. avice disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Linux districts Due to (or as a consequence of) Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Other (specify) Day Year Pregnant at time of death 2 🗌 No the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ATH

AUG 2 6 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daisy Mae FITZ August 2 691 0556 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year) 1925 1 M 2 X F Hours Oct. 12 Director 216-22-7871 85 Maryland Usual Residence of Deceden show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland batment of Health and Mental Hygiene. To contant: If item 27 is marked other than "natural", or items 23a or 28a-f shoordarts If item 27 is marked other than "natural", or items 23a or 28a-f shoordarts in time 25 and 25 marked other than "natural", or items 25 or 28a-f shoordarts in items are security or other traumatic event, the Medical Examiner must be notified at event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13407 Maugansville Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) GED 12 College (1-4 or 5+) cook nursing home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Franklin Sword Pearl Lulu Carbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheri Fitz - daughter 13407 Maugansville Rd., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, St. Paul's Cemetery 8/25/11 4 Donation 5 Other (Specify) Clear Spring, Md. Signature of Funeral Service Lice Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Altero Onset and Death Ph\_sician/ disease or condition resulting in death) mino Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence or, physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Vear Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 2 🗌 No 1 Yes 2 9 Unknown detached by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings avallable prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗆 Inpatient 2 🕽 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this the funeral : After t Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending iniury Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Medical Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of egistrar's Sigr State Registrar

(Item 23a) (Type, Prin

29c. License number

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28651 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0332 Fields Cletes Dwight 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Allegany WMHS-RMC Cumberland 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 X M 2 D F Hours Aug 73, 1941 236-64-7951 70 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. Count death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director WV Hampshire Springfield 1 Yes 2 X No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 26763 USA Prospect St. & Rt. 28 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married ģ 1 ☐ Yes 2 ☐ No Specify Specify white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Factory .aborer Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Fields Erma Crock 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 26763 19a. Informant's Name/Relationship (Type, Print)
Connie Haslacker sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burjak 2 Cremation 3 Removal from State Springfield Cemetery 8/24/201 WV Springfield 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses 22. Name an Scarpellif Porteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ citheru Scleratic 9 Cal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury Exami the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician d be detached for use as the humin Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sł autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 ☑ No မှ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director and the funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work: 1 🗌 Yes 2 🗆 Na 2 Accider
3 Suicide Accident Investigation pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 23,2011 36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKRAMADIT 31. Date filed (Month, Day, Year) SETON 32. Registrar's Signature State SEP 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28652 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Z:25am Physician/ JOHN MICHAEL GYORDA, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** a 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) PA ountry) **Funeral** Min. 1 XM 2 □ F 9 (M3)th, Pay 333 77 579-42-7788 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State death with the Maryland Director 1 Yes 2X No LA PLATA MD. CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 5945 KRIPPLE KREEK PLACE 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

1X Yes 2 No USAF Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Specify: WHITE 1 ☐ Yes 2 XNo Specify. 5-0036 KOREA Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry BRISTOL-MYERS Decedent's Education (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) PHARMACEUTICALS PHARMACEUTÍCAL REP. Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve FRANCES CONRAD မှ JOHN M. GYORDA, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5945 KRIPPLE KREEK PL. PATRICIA GYORDA-SPOUSE LA PLATA, MD. fimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 XBurial 2 Cremation 3 Removal from State MD° VETERANS TO CEM. 9-8-11 CHELTENHAM, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to ( a a consequence of Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c, License number 29b. Signat AUGUST 2011 who completed cause of eath (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

31. Date fited (Month, Day, Year) SFP 0 8 2011 2064

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8-20-2011 2350 Marie A. Hawkins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Prince Georges Cheverly 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗌 M 2 🖾 F Months Davs Hours Min. (Month, Day, Yea Danville, Director 67 -1943 577-58-2245 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince Georges Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 United States 700 Narrow Leaf Drive of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: Black 3 ∰ Widowed 4 ☐ Divorced If Yes, Give Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3yrs. Protective Services Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christopher C. Hairston Crissie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josilyn C. Hairston/Daughter 700 Narrow Leaf Drive Largo MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o E Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Memorial 8-27-2011 Landover, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Fatal Cardiac Arrhythmia Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions. Due to for an e-nonnequence of) cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hypolipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Control of the contro in the past 12 months?
1 Yes 2 No Month Day Pregnant Unknown Year Pregnant at time of death 1 Yes 2 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 2 🖾 No မ 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 🛚 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: In the hour of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. in the basis of extending and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner **Gertifying Nurs** 29c. License number 29d. Date signed (Month. Dav. Year) δ rson who (Type, Print) ne and a 4000 Mitchel∱ille Rd. #A 204 Bowie MD 20716 Kimbe 1 line 31. Date filed (Month. D State 32. Registrar's Signature Registrar

Harris, Weller Baltimore, Maryland 21215-0036

		-	For State Registrar	State of	Maryland		artment of F tificate of D		nd Mental H	lygier Reg.	201	1 2	28654
	Physicia		1. Decedent's Name (First, Midd Weldon W.	Harris					2. Date of Month		Day	Year POI	3. Time of Death
- 10000	Medic Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death						//		4c. County	of Death	orge's
	Funeral		5. Social Security Number		Age (In yrs. last		Lanham  If Under 1 Year  Months Days	If Under 2 Hours		Birth Day, Yea		9. Birthpla	ace (State or Foreign
	Director		240-54-0611 Usual Residence of Decedent	TASIM 2 LIF	72	Yrs.		110010	March	3, Yea	ľ939	North	Carolina
	aryland a-f shor	ctor	10a. State 10b. Count  Maryland Prin	<sup>y</sup> ce George <b>'</b> s	10c. City, To	own or Loc nham	cation					10	d. Inside City Limits
	th the Mis 3a or 28i t be notii	Funeral Director	10e. Street and Number 5503 Linwood				10f. Zip Code 20706				Og. Citizen of What Country? United States		
936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. and any injury or other traumatic event, the Medical Examiner must be notified at once.	۾	11. Marital Status  1 Never Married 2***M: 3 Widowed 4 Divorce	12. Was Deceder	s? □ No	If	Vas Decedent of Hi	n, Mexican,	n? (Specify Yes or I Puerto Rican, etc.)	No-		14. Race - American Indian, Black, White, etc.	
12-0	72 hours "natur edical	Completed	(Specify only high	ent's Education nest grade completed)		(Give k	ent's Usual Occup	ation Juring most o	of working	16b	. Kind of Bu	ısiness Indu	ustry
212	within 7 giene. ier than ; the M		12 years		or 5+)		NOT use retired) urchaser				Gove	ernmer	nt 
Maryland 21215-0036	d be filed fental Hy irked oth tic event	To Be	17. Father's Name (First, Middle, Foracker H						's Name (First, Mid Lie Burru		en Surname	)	
Man	d 2 should alth and N 27 is ma r trauma		19a. Informant's Name/Relation Barbara Harris						or Rural Route Nur Lanham,			tate, Zip Co	ode)
Baltimore,	Page 1 and lent of Hei nt: If item ry or othe		20a. Method of Disposition  1 → Burial 2 □ Crematio 4 □ Donation 5 □ Other		ate cem	etery, crem	sition (Name of natory or other place		Date ag 27, 20		Location -	•	
Balti	permit. F Departir Importa any inju once,		21. Signature of Funeral Service	-	f 70	22.	. Name and Addres	s of Facility	Stewart id, NE Wa	Fune	ral Ho	ome,	Inc.
	hysician/		Sa. Pap Enter the disease, shock, or heart failure. List immediate Cause (Final disease or condition	or complications that cause on each	sed the death. D		r the mode of dying		ardiac or respirator				Approximate Interval Between Onset and Death
mark!	Medical Examiner		resulting in death)	Due to for	as a consequent	ce of):	ONI	a_					
	nsit	Examiner	Sequentially list conditions, if ny analysts in minimus to cause. Enter Underlying Cause (Disease or iinjury	Due to or	as a consequenc	ce of):							
	cate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or	as a consequen	ce of):							
3760	proate be physic as the br	Medical		d				-					
Box 687	to the propriat of Attending Priysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 🗀 Fetal de it at time of deal	eath 3 🗌	Ectopic pregnanc Other (specify)	у		_	23d. Dat Mo	te of deliver	Y Day Year
P.O.	iles that the dea signed by the a Id be detached f	by Ph	Part II. Other significant condit	ions contributing to deat	h but not resultin	ng in the u	nderlying cause giv	ren in Part I.					cause of death?
rds,	requires been signated should b	eted							1				ably 4 Unknown
Division of Vital Records,	rne law cate has page 2 s	Completed							a	utopsy erformed es 2	2   F	orior to com death?	pletion of cause of
ita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			Othe	ar.	(Check only one)				
of V	g rnys er this eral di	:e: To	27. Manner of Death	28a. Date of i	njury 28 Day, Year)	b. Time of	28c. Injury	4 ⊔ Nur ≀at	sing Home 5 P				
ion	death. stor: Aft the fur	Certificate:	1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Coul	tigation		injury		Yes 2 1					
Divi	tal or A rs after al Direc ed in by		4 Homicide deter		etc. (Specify)	, iaiii, sire	et, factory, office			Town, Sta		er or Hurai F	Route Number,
	to the hospital of Attending Physician: The law, within 24 hours after death.  To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2:	29a. Certifier (Check only one): 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and manner as stated only one and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) and the									to the caus	se(s) and manner stated	
	within 2 To the comple	7	29b. Signature and the of certifi	er			29c. License	number 944	G	29d.	Days signed	(Monty), D	ay, Year)
	80		30 Name and address of person	who completed dause to	zeath (tem 23	NT	9-8118 E	ooth	uck Rde.	(ar	ham	mDe	20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of Health ar	nd Mental Hyg	giene	
				Certificate of Death	1	Reg. N2.	28655
	Physicia	n/	Decedent's Name (First, Middle, Last)	,	2. Date of Dea Month	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death	13.40 M
	Examin	er	4mm C	Baltimore	Seatt	Baltimore	2
	Funeral	ľ.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24		9. Birtho	place (State or Foreign
	Director		215-26-2025   1 XI M 2 L F   79 Yrs  Usual Residence of Decedent	i. Months Days Hours	Min. (Month, Day, Oct. 1	8 1931   Mary	Tand
	and show at	or	10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	Maryli 28a-f	Director	Maryland Washington Willia	amsport			1 🎇 Yes 2 □ No
	a or 2	al Di	10e. Street and Number	10f. Zip Code		10g. Citizen of What Coun	try?
	th with ms 23 must	Funeral	243 Maplehurst Avenue	21795		USA	
	or ite	by Fu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 M Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F</li> </ol>	Puerto Rican, etc.)	14. Race - Americ Black, White,	
ဗ္ဗ	rs afte iral", Exar	ed b	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 No Specify:		Specify: Wh	nite
Maryland 21215-0036	2 hou "natu edical	plet	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of	f working	16b. Kind of Business Inc	dustry
12	ithin 7 ene. • than he Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	e.DONOT use retired) ine Line Inspecto		Truck Man	ıfacturer
<u>0</u>	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		s Name (First, Middle, f		Hacturer
<u>lan</u>	should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	입	John T. Henry		Light	,	
lan,	should be file and Mental I <b>7 is marked o</b> raumatic eve		f	lailing Address (Street and Number of			Code)
<b>≥</b>	1 and 2 should be if Health and Men item 27 is marke other traumatic			)5 Spielman Road,			
Baltimore,	0		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place)	Date	20c. Location - City or To	wn, State
<u>=</u>	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify) Cedar I	Lawn Mem. Park 8/ 22. Name and Address of Facility		Hagerstown, Funeral Home	
Ba	Depti Impo		Cott Ma Junior	415 E. Wilson Bl			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	~			Approximate Interval Between
her.	Physician/		Immediate Cause (Final disease or condition resulting in death)  a. Impediate Table 1 in the case of condition resulting in death)	Contin			Onset and Death
	Medical Examiner		resulting in death)  a. Lie to (or as a consequence of):	1111511111			
		e	Sequentially list conditions, b. Vascular D	15895C			
	ed	Examiner	cause. Enter Underlying Cause (Disease or linjury				
	execui in and ial-tra	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
ဥ	te be e tysicia ne bur	dical	d				
289	rtifical ling ph e as th	Physician/Med	IF FEMALE:				
Box	ath ce attend for us	cian,	23b. Was decedent pregnant in the past 12 months?  1	3  Ectopic pregnancy 5  Other (specify)		23d. Date of delive Month	ery Day Year
ň	he deg	hysid	1   Yes 2   No 4   Pregnant at time of death 9   Unknown	5 - Other (specify)			
Д. О.	that t ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tol	bacco use contribute to th	e cause of death?
ds,	quires en sig ould b				1 🗆 Y	es 2 ☐ No 3 ☐ Prob	pably 4 🛱 Unknown
Vital Records,	aw rei as be	Completed			24a. Was a autops	sy prior to coi	osy findings available mpletion of cause of
<b>4</b>	: The I	Con			perfor 1 🗆 Yes	med? death? 2 No 1 ☐ Yes	2 🗆 No
ī	sician certifi rector	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Vinpatient 2 FB/Outpa	26. Place of Death (		_	
01 <	y Physer this eral di	e: To	27. Manner of Death 28a, Date of injury 28b, Tim	e of 28c, Injury at		ence 6 Other (Specify) ow injury occurred	)
u C	ath. r: Afte	Certificate:	1 Matural 5 Pending (Month, Day, Year) injul	y work? M 1 ☐ Yes 2 ☐ No	1	···,,	
DIVISION	r Atte ter de recto	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	treet and Number or Rural	Route Number,
ā	oital o						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, des (Check 2 Medical Examiner: On the basis of examination and/or in Paraticipant, 2 the best of my knowledge.	vestigation, in my opinion, death occu	rred at the time, date an	nd place, and due to the cal	use(s) and manner stated.
	To the within To the compl	≥	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge.  29b. Signature and title of certifier	ge, death occurred at the time, date an 29c. License number		cause(s) and manner as sta 29d. Date signed (Month, L	
	M		Della Watmanam)	101680		8/21/2	011
	G.		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		J -1/20	
	5+1		Uluchi Amaram 2256	101680 e, Print) Exert St Ball	Finnep, M	7 21201	
	Stat Registra	e ir	31. Date filed (Month, Day Year) 32. fegistrar's Signature	part !			
				_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 28656 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ lliamt. Month 1055 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 1 XM 2 🗆 Days Hours Feb. 3.1934 215-30-4566 Mary Tand Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits must be notified at Director Maryland Anne Arundel Edgewater 1 Yes 2X No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 21037 Funeral United States or items 23a 3736 Ramsey Drive within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Armed Forces? Black White etc 1 Never Married 2 Married ð Maryland 21215-0036 White If Yes, Give 1955-1958 Year or Dates. 1 ☐ Yes 2 XNo Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) private Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helga Knauer g William F. Hense. permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Туре, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3736 Ramsey Drive Edgewater, Maryland 21037 Mildred Hense -wife Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Metropolitan Crematory 8/25/2011 matory or other place Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 enald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, 60513 disease or condition 2 upas Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or linjury that initiated events use as the burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign, page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 우 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) U64379 8 24 1800 30. Name and address of per son who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Physician/ LINDA LEE HENSON tugus Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death HARLE IV ISTA ENTER Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F WASH., D.C. 10-26-1947 63 579-58-7409 Director Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD -CHARLES 1 Yes 2 No WALDORF 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral #3 WALNEY COURT 20602 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or à 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) CUSTOMER SERVICE REP. 12th SAFEWAY FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH PAIR CARRIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau DAVID HENSON, SR. - SPOUSE #3 WALNEY CT. WALDORF, MD. 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) METROPOLITAN CREMATORY 8-31-11 21. Signature of Funeral Service Licensee M00479 2) Name and Address of Facility
AYMOND FUNERAL SERVICE, P.A.
I.A PLATA, MARYLAND 20646 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last UMON pue burial-tran Due to (or as a consequer of attending physiciar Physician/Medical that the death certificate be as IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No For Day Month Year Pregnant at time of death ed by the a detached t P.O. Part II. **Other significant conditions co**ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case refin Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man r of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation work 1 🗌 Yes 2 🗌 No Accident 24 hours after deat Funeral Director: within 24 hours after dear To the Funeral Director completed filled in by the 3 Suicide 6 Gould not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) etermined Medical 29a. Certifier Certifying Physician: To the best of my knowledge death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my kno wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SON 9 ON 31. Date filed (Month, Day, Year) 32. Registrar's Signature 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 2011 3:42 PM Physician/ JOHN SAMUEL HUFFER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, May 12, 9. Birthplace (State or Foreign Country)

Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 578-44-0260 1 **X** M 2 □ F Months Days Hours 85 1926 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at rector 1 X Yes 2 No Frederick Maryland Frederick ۵ 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 21701 United States of America 528 Mary Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ※ No Black, White, etc. 1 Never Married 2 Married Yes ò Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit, Page 1 and 2 should be filled within 7 Department of Heath and Mental Hyginer Important: If item 27 is marked other than any injury or other traumatic mental progression. Elementary/Seconday (0-12) College (1-4 or 5+) City Government General Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ George Carlton Huffer Lora Grace Keller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 528 Mary Street, Frederick, Maryland 21701 Debra Downs / Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State August 28, 2011 Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Name and Address of Facility
Keeney & Bastord P.A. Funeral Home
106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cerebro Vascular Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopa Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated propts.) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate has performe 1 🗌 Yes 2 🗌 No Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury 1 Natural 5 Pending 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: Dest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the bask of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43091 8-27-11

Registrar
DHMH 17 Rev 7/2009

State

House Ave Frederick MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Society Zaidi MO Soi Tak

32. Regisar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 25 2011 Physician/ HOFFMAN AUGÜST EDWARD PAUL 1:12A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARY'S 35375 ARMY NAVY DRIVE MECHANICSVILLE ST. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** 1 🙀 M 2 🗆 Days Min. Months Hours MAY 11 , 1928 WASH., DC 579-34-3288 83 **Director** Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes XXNo ST. MARY'S MECHANICSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35375 20659 S. ARMY NAVY DRIVE A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

\*\*EXYes 2 \sum No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Vidowed 4 □ Divorced WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) ROOFER ROOFING any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE HOFFMAN BEULAH WHEELER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, DIANA GRAY/DAUGHTER 35375 ARMY NAVY DR., MECHANICSVILLE, MD20659 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific) SEPTEMBER VETS.CEMETERY CHELTENHAM, MD 1, 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility  ${\tt RAYMOND}$   ${\tt FUNL}$  . SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Other (Specifical examiner? Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury injury Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address

JENNIFE K

31. Date fred (Month, Day, Year)

SEP 0 8 2011

SCHMIDT, DO 40900 MERCHANTS LANE SUITE 205 LEONARDTOWN, MD

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

8-26-

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Steven Jack Hirsel	1	St - For State tegistrar	tate of Maryla	and / [		rtment of tificate of			l Mental I		Reg. No.	20		28661
Physician Medical Examine	/	1. Decedent's Name (First, Midd STEVEN JACK	lle,Last) HIRSO	CH						2. Date of De Month August 2	ath	Year 1	3	3. Time of Death 2035 hrs
)	_	4a. Facility Name (if not institution 8601 Ewing Drive	on, give street and no	umber)		4	b. City, To Bethes		ocation of Dea		40	County of Montgome		
Funeral Director		5. Social Security Number 131-28-8206	6. Sex		n yrs. la 75	st birthday) Yrs.	If Under Months		If Under 24H Hours M	_		10	Foreign	place (State or htry) Germany
nd show any ice.		Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	omery	- 1		Town or Locati nesda	on					-		10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23s or 28s-f sho must be notified at once	Disacro	10e. Street and Number 8601 Ewing Dr.					10f. Zip 0				_	zen of What	Countr	ry?
ral",	\$  -	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Yes	orces? 2 X ar	No	lf Yo 1 □	es, specify Yes 2	Cuban,	Mexican, Puer			14. Race White, Specify:	etc. Wh:	ite
Z 12	nalaldillo	Elementary/Secondary (0-12)	College (	1-4 or 5+)			ost of work	ing life. St	DO NOT use re	etired)	Ps	ychia		austry
1121 Id be fil Aental F aarked event, o		17. Father's Name (First, Middle, Kurt Hirsch 19a. Informant's Name/Relations	h			19b. Mailing	Address		Hilda	ne (First, Middle, r Rural Route Nu		Marcks		Zip Code)
MD nd 2 sho alth and a 27 is	L	Linda L. Hirscl 20a. Method of Disposition 1 Burial 2 Cremation		rom State	CI	lace of Disposi rematory or oth	tion (Name er place)	e of cem	etery,	Date Date	20c.	Location - C		
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	-	4 Donation 5 Other Sp. 21. Signature of Funeral Service	pecify:	/	Met:					ig.28,20 it Funer Rd. Belt				
Physician /Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	on each line.			Do not enter th	e mode of	dying, s	such as cardiad	Rd. Belt or respiratory ar	SV1	<u>le, M</u> ock, or heart	D 20	0/05 Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a b.	consequ	ence of)	); <del>T</del> a 22 (2	THEOX	ılıa	LION					
), be executed ician and urial - transit	CYallin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
	U -	X UNPENDED F FEMALE:					er me	,g9	19 9–9–	ll sm	230	d. Date of de	alivery	
n of Vital Records, P.O. Box 6876C ding Physician: The law requires that the death certificate h. After this certificate has been signed by the attending physician director, page 2 should be detached for use as the born: To Be Commisted by Physician/Me	i yalcıdır.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregulation of the pregnant at time of death 5 Other (Specify) 9 Unknown							nancy		Month	Da	y Year	
s, P.O. Be ires that the de signed by the detached f	2	Part II. Other significant condit	dons contributing t	o death bu	ut not re	sulting in the u	nderlying c	ause gi	ven in Part I.			acco use contribute to the cause of death?  2  No 3 Probably 4 Unknown		
of Vital Records, P.O. og Physician: The law requires that the Net this certificate has been signed by meral director, page 2 should be detach or To Ba Completed by P.										1 Yes		prid dea	or to cor	psy findings available mpletion of cause of 2 No
Vital   hysician: this certif		25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient	2 🔲 I	ER/Outpatient		- 1	of Death (Chec other   Nurs	k only one) sing Home 5	Reside	nce 6 🗸	Other: \$	Scene
Division of Neption of Neption of Neption or Attending Ph. Nours after death.  Oeral Director: After tillilled in by the funeral Centification: Tillication: Till		27 Manner of Death 28s Date of Injury 28h Time of Injury 28c Injury at Work?								purpos alcoho medicat 28f. Location	28d. Describe how injury occurred subject purposefully overdosed on alcohol and prescription medication 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8601 Ewing Dr.			
Division  To the Hospital or Attention 24 hours after death and the Fuoral Director: completely filled in by the Hodical Certificati		one) 2 Medical Exa	hysician: To the beaminer: On the basis and manners	of examina		e, death occun	ed at the ti			nd due to the cau	se(s) an	d manner as ce, and due	to the	cause(s)
		29b. Signature and title of certifie	iasself 1					License O.C.M	number 1.E.		1	ust 26, 2		h, Day, Year)
		30. Namé and address of person Melissa Brassell, MD	Assistant Me	dical Ex	xamin	er 900 W	. Baltimo	ore St	reet, Baltim	ore, MD 212	23			
State	e	31. Date filed (Month, Day, Year)	32. R	egistrar's S	Signatur	Like								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per dvr 2921 11-4-11 vt. State of Maryland / Bepartment of Health and Mental Hygiene 28661 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 20, 2011 Year 5:30 P M Henry A. Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hyattsville St Thomas More Medical Complex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ፟ M 2 □ F Months Hours Min (Month, Day, Days 238-46-8701 **Director** 78 1933 North Carolina Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director Marvland Prince George's Beltsville 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20705 United States 3109 Fallston Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 0 þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: American "natural" Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Biologist years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sally Jones Rufus Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 Fallston Avenue Beltsville, MD 20705 Jacquelin M. Jones - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State cemetery, crematory or other Lee's Crematory 1 Burial 2 X Cremation 3 Removal from State Clinton, MD Aug 27, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signatura of Fineral Service Liegns 4001 Benning Road NE Washington, DC Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 8 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ę Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Multiple Infected Decubitus Ulcers 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? page death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) Hospital 1 Yes ZX No No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

funeral director, the

within 24 hours after death.

To the Funeral Director: At completed filled in by

> State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 University Blvd. E. #208 Hyattsville, MD 20783 Ajit Kurup, MD

31. Date filed (Month, Day, Year) AUG 2 6 2011

1 Natural

Accident

Suicide

4 Homicide

only one) 29b. Signature and title of corti

29a. Certifier

5 Pending

Investigation

determined

6 Could not be

32. Registrar's Signature racks

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1)006368

29c License number

🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

8

29d. Date signed (Month, Day, Year)

11

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8729/2011 7:56 а м Donna Reed Jennings Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 13507 Herman Myers Rd. Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 12/9/1956 219-66-2044 Director Pennsvlvania Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral 13507 Herman Myers Rd. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Specify: White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Retail 1 and 2 should be filed with Health and Mental Hyginitem 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thurman Marshall Beatrice Mullenix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Jennings / Spouse Department of Health Important: If item 2 any injury or other t 13507 Herman Myers Rd., Hagerstown, MD 21742 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory 8/30/2011 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Smithsburg, Maryland 4 Donation 5 Other (Specify) Size re of Funeral Service Lice Rest Haven Funeral Chapel 22. Name and Address of Facility 1601 Pennsylvania Ave., Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, page 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 

Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) Yona 1130 Opal 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

**SEP 08** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28663 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Steven Ross **Kettles** 26 2011 8:20 A August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 39476 Golden Beach Road Mechanicsville St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗶 M 2 🗆 F Months Hours Min 11/16/1953 **Director** Washington, D.C. 219-58-9431 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö an "natural", or items 23a or Medical Examiner must be Funeral 26785 Tin Top School Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed win... rtal Hygiene. 'ser than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ĝ Clerk Food Industry event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file h and Mental F is marked of ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Harry W. Kettles Mariorie Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Divver/Friend 39476 Golden Beach Rd., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aughate 28. 1 🔲 Burial 2 🛣 Cremation 3 🗀 Removal from State 2011 4 Donation 5 Other (Specify) Charlotte Hall, MD Brinsfield-Echols Cr. 21. Signature of Fuperal Service Licens 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 MOO174 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final small cell Pnysician/ Non disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): ending physician a use as the burial-Medical death certificate be Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year Pregnant at time of death ed by the a 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performe death?
1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate Yes 2 No Division of Vital rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 🗌 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5  $\square$  Pending 1 Natural Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Suiciue ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 050686

State Registrar

DHMH 17 Rev 7/2009

GURDEEP

31. Date filed (Month, Day, Year)

AUG 29

6510 Kenilworth Ave., St. 2800, Riverdale,

20737 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHHABRA

Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28564 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ 80 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Julia Manor Washington Health HOUSE 8. Date of Birth (Month, Day, Oct. 4 g. Birthplace (State or Foreign . Social Security Number If Under 1 Year Funeral 1 □ M 2 🛭 F Months Days Min Hours 1919 Country) Ohio 218-80-3961 91 Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Washington Hagerstown Maryland | 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 21742 851 Dewey Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) Her own home 8 0 Homemaker marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unknown) Dominica Frank Shindle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 13008 Mt. Zion Road, Sabillasville, Md. 21780 Cynthia Krumpe - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Brier Hill, Pennsylvania 4 Donation 5 Other (Specify) LaFayette Mem. Park 8/24/2011 22 Name and Address of Facility Minnich Funeral Home 21. Signal Tuneral Service License 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Dreast Metasiatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ြု 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🔲 Yes 1 X Natural 5 Pending 2 🗌 No Accident Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge

-10

State

31. Date filed (Month, Day,

333 MILISTREET, HOGERSTOWN: MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 10:55A.<sub>M</sub> 1. Decedent's Name (First, Middle, Last) 2. Date of Death **KHAWAJA** Physician/ Adentst 25° 2011 ear Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Howard **Examiner** 4b. City, Town, or Location of Death 8829 Mission Road Jessup 5. Social Security Number 7. Age (In yrs. last birthday) 73 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 213-65-9815 1 **∑** M 2 □ F Months Hours Feb. 20, 1938 India Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Howard 1 Yes 2 No Jessup 10g. Citizen of What Country? United States 10e. Street and Numbe 10f. Zip Code 20794 Funeral 8829 Mission Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, 1 Never Married 2 Married Completed by Specify: South Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Food Inspector Be 18. Mother's Name (First, Middle, Maiden Surname) Soliha Jaffer 17. Father's Name (First, Middle, Last) Ghulam Khawaja Jaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8829 Mission Road Jessup, Maryland 20794 19a. Informant's Name/Relationship (Type, Print) Mustafa Ghulam Khawaja -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Maryland National Man. Pk. 8/26/2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Glioblastoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transi attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 1 ☐ Yes 2 ☐ Unknown the ; 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ right hemiplegia; seizures Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate 1 ☐ Yes 2 🕅 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 A Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10 29c. License number 29d. Date signed (Month, Day, Year) D0064099 25 2011 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause

State Registrar Jaishri Blakeley,

31. Date filed (Month, SEP 0 8

M.D.

32. Registrar's Sign

15/50 Orleans Street, 1M16 Baltimore, Maryland 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

		•	For State Of Maryland State Registrar		tificate of D			Reg. No. 2011	28666		
	Physicia		1. Decedent's Name (First, Middle, Last)  Emily Suzanne Keller				2. Date of Dea		3. Time of Death 11:05 AMM		
	Medic Examin		4a. Facility Name (if not institution, give street and number) 6441 Sunset Drive		4b. City, Town, or Freder	Location of Death		4c. County of De	ath		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g. e (4 <sup>Year)</sup> 1946	Birthplace (State or Foreign Country) laryland		
	faryland Ba-f show tified at	rector	10d. Inside City Limits 1 □ Yes ※XX No								
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 6441 Sunset Drive	H-47	10f. Zip Code 21702	2		10g. Citizen of What 0	Country?		
980	2 should be filed within 72 hours after death with the Maryland than domentally typiene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☐ Yes 2 N No If Yes, Give Year or Dates.	If	Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2 X No	Black, Wh	nerican Indian, lite, etc. Thite				
Baltimore, Maryland 21215-0036	ithin 72 hou iene. r than "nath the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	lent's Usual Occupa kind of work done d O NOT use retired) Iomemaker	ation uring most of work	ing	16b. Kind of Busines Own Home			
land ?	d be filed w fental Hyg irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) John Straughn Insley			18. Mother's Nam	e (First, Middle, 1 Jeanett	Maiden Surname) .e Crim			
, Mary	nd 2 should ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Donald L. Keller, husband					, City or Town, State, , MD 21702			
timore	permit. Page 1 and 2 should be f Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic ev		1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispos Remetery, crem COTMED	sition (Name of natory or other plac Cemetery	<sup>∍</sup> Sept. 2,	Date 2011	20c. Location - City Middletov			
Ball	permit Depart Impor any in		21. Signatur of Funeral Service Models Model								
	Physician/ Medical Examiner	L	23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions  Due to (or as a consequentially list conditions	IC PAN				est,	Approximate Interval Between Spet and Death MONTUS		
00	te be executed tysician and te burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d								
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnate 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of 6 9 ☐ Unknown	23d. Date of Month	delivery Day Year						
Is, P.O.	uires that tl signed by Id be deta	by	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		tobacco use contribute to the cause of death?  Yes 2 M No 3 Probably 4 Unknown			
Vital Records,	The law requ cate has beer page 2 shou	Completed					24a. Was a autop perfo 1  Yes	prior to death	autopsy findings available to completion of cause of ? Yes 2  No		
Ita	sician; certific rector,	Be o	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Othe	ace of Death (Chec					
n of v	nding Phys th. After this funeral di	cate: To	1 ☐ Nes 2 M No 1 ☐ Inpatient 2 ☐ 27. Manner of Death 1 M Natural 5 ☐ Pending 2 ☐ Accident Investigation	28b, Time of injury	28c. Injury work	at		dence 6 Other (Sp low injury occurred	ecify)		
Division of	al or Atter s after dea al Director ed in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,		
	n Hospit n 24 hour ne Funera	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my know 2  Medical Examiner: On the basis of examination 3  Certifying Nurse Practioner: To the best of m	n and/or invest	tigation, in my opinio	n, death occurred a	t the time, date a	and place, and due to the	ne cause(s) and manner stated.		
	To the To		29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	nth, Day, Year)		
	124		30. Name and address of person who completed cause of death (Item DAVIS COSGROVE, THE JOHNS HOPKING			etu Wolfe s	STREET, BA	LTIMORE, MI	3 21287.		
f	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registrer's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28667 State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Aug 15. 2011 4:45 PM Keyser Henry 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic actions.

For State Registrar

Physician/

Medical

**Examiner** 

**Funeral** Director

Physician/ Medical **Examiner** 

Baltimore, Maryland 21215-0036

hours after death.

uneral Director: After this certificate has been signed by the attending physician and
ed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

•	To the Hospital or Attending Physician: The law requires that the death certificate be executed
1	within 24 hours after death.
X	To the Funeral Director: After this certificate has been signed by the attending physician and
3	completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit
3	

Month, Day, Year)

SEP 0 8 2011

	217-10-		1 XM 2 LJ F	95	Yrs.	Months Bays			Jul 1	6, 1	916	ME	)
_	Usual Residence of Decedent         10b. County         10c. City, Town or Location											10d Inside	e City Limits
recto	MD Allegany Cumberland											Yes 2 No	
i Di	10e. Street and Num	nber			10f. Zip Code				10g. C	itizen of What			
nera	512 W	inifred I	Road				215				U	SA	
Fui	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cub	lispanic Orig an, Mexican	gin? (Spec , Puerto R	ify Yes or No- tican, etc.)	-		American Indian Vhite, etc.	,
i by	1 Never Marri		ed 1 Yes 2 If Yes, Give			☐ Yes 2 ☐ XNo					Specify:	white	
etec	3 LAVIdowed 2	15. Decedent	Year or Dates.			ant'e Heual Occur	nation			16h	Kind of Busine		
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)  12 College (1-4 or 5+)  Carpenter Susual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Carpenter Self-em												
Be	17. Father's Name (F	irst, Middle, La	nst)		<u> </u>	<u> </u>	18. Mothe	er's Name	(First, Middle				
욘	Walt	ter Cha	rles Keyser				L	.illian	Lange				
	19a. Informant's Na					Address (Street 509 Key			Route Numb	er, City o	or Town, State	, Zip Code) MD	21555
	20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 ☐ Removal from State	. cem	etery, cremi	ition (Name of atory or other pla natomical	Board	D	ate 8/16/201	1	Location - City Baltim	y or Town, State	MD
	21. Signature of Fun			-	22.	Name and Addre	ss of Facilit	Yeral H	ome, PA	ا ما ما ما	MD 245	02	
	23a, Part 1. Enter th		complications that cause	d the death. [	no not enter						<u>, MD 215</u>	Approxi	mata
	shock, or hear	t failure. List or	nly one cause on each lin	e.	Jo not enter	1	1 1	ouruluo or	respiratory a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval	Between nd Death
	disease or condition resulting in death)		a	non		Very.	h) ca	×				10	123
	roodicing in doctin	- 1	Due to (or as	a consequer	de of):								
iner	Sequentially list cor if any, leading to im cause. Enter Under	nditions, mediate	b. Due to or as	a consequen	ce of):								
xan	Cause (Disease or i that initiated events	injury	c. — —	c									
cal E	resulting in death) L	_ast	Due to (or as	1									
ledi			<u> </u>										
In/N	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregnancy	y	Catania management					23d. Date o	f delivery	
sicia	in the past 12 n 1  Yes 2	nonths?	4 Pregnant			Ectopic pregnan Other (specify) _	cy				Month	Day	Year
hys	9 🔲 Unknown		g 🔲 Unknown										
by F	Part II. Other signifi	icant condition	ns contributing to death I	out not resulti	ng in the un	iderlying cause g	iven in Part	I.				te to the cause	
ted									1 🗆	Yes :	2 L <b>X</b> 10 3 [	Probably 4	L.J Unknown
Completed by Physician/Medical Examiner									24a. Was auto perl	an opsy formed?	prior	e autopsy findin r to completion th? I Yes 2  No	
	25. Was case referre	ed to medical	Ţ			26. F	lace of Dea	th (Check		الساے	140]	,,03 2 60110	
To Be	examiner?	PNo	Hospital:	ient 2 🗆 EF	VOutpatient	: 3 🗆 DOA Oth	ner: 4 PNI	ursing Hon	ne 5 🗆 Res	idence	6 Other (S	Specify)	
	27. Manner of Death	_	28a. Date of inju	ıry 28	Bb. Time of injury	28c. Inju wor	ry at		8d. Describe				
fica	Natural 2 Accident	5 Pending Investig	ation	,, (Out)	ii ijali y		Yes 2	No					
Certi	3	6  Could n determin	28e. Place of In						ocation (Street and Number or Rural Route Number, ity or Town, State)				
Medical Certificate:	(Check 2	☐ Medical Ex	Physician: To the best of caminer: On the basis of Nurse Practioner: To the	examination a	nd/or investi	gation, in my opin	ion, death or	ccurred at	the time, date	and place	ce, and due to	the cause(s) and	i manner stated.
-	29b. Signature and t	V 1 1	1			29c. Licens					ate signed (M	onth, Day, Year	)
		1	mo			Doo	332	80		A	ng 16	1105	
	30. Name and addre	ess of person w	ho completed cause of	death (Item 20	3a) (Type, Pr								~

State

Registrar

025 KENTAVE, STE. 101 CHINBERLAND MID 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		artment of H		and M	lental Hyg	jiene		00660	
			Registrar	leg. No		28668						
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Anna Cecilia Lascl				2. Date of Dear Month	Day Year		3. Time of Death 7:07 P M		
	Medio Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location	f Dooth	August		ty of Deat			
	Examin	er	St. Mary's Nursing Home			Leona		מישו	4C. Cour		Mary's	
	Funeral		5 Social Security Number 6 Sex 7 Age (In urs lost to	birthday)	If Under 1 Year	If Under 2	24 Hrs	8. Date of Birth		9. Bir	thplace (State or Foreign	
	Director		215-62-9071 1 M 2 T F 97	7 Yrs.	Months Days	Hours	Min.	0872971	913_	Ma	ryland	
	D W	L	Usual Residence of Decedent           10a. State         10b. County         10c. City, To								Land trails of the limits	
	ırylan I-f sh ied a	[ cg	, , , , ,	own or Loc							10d. Inside City Limits	
	or 28g		Maryland St. Mary's		Leonardt	own			10- Citizon	s What Co		
	/ith th	ā			206	EΛ			rog. Gilizeri (	g. Citizen of What Country?  USA		
	ems er mu	Funeral Director	40420 Anna Lane 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		gin? (Spec	cify Yes or No-	14. R		erican Indian,	
ထွ	or it		1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2X No	- 1			, Puerto F	Rican, etc.)	В	lack, White	e, etc.	
ဗ္ဗ	ural" ural"	Completed by	3   Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 ĀNo	Specify:			Spec	ify: Wh	ite	
2	"nat	ple	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done di		of workin	ng I	16b. Kind of	Business	Industry	
12	thin 7 ene. than he M	Son	Elementary/Seconday (0-12) College (1-4 or 5+)		omemaker					Oran	. Home	
d 2	filed within 72 hours after death with the Maryland al Hygiene and the first than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)	п	T	18 Mothe	r's Name	(First, Middle, N	Aaiden Surna		Home	
an	ould be filed within 72 hours after death with the Maryland di Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at	ပ	William Miedzinski					es Paw]		,,,,,		
ary	should be file n and Mental H 7 is marked o raumatic eve			9b. Mailin	g Address (Street a					, State, Zij	p Code)	
Σ	d 2 sl alth a n 27 i er tra		Killian F. Laschalt, III/ Son   1	18286	Stoney P	oint	Road	l, King	George	e, Vi	rginia 22485	
ore	of He of He fiten roth		20a. Method of Disposition 20b. Place		sition (Name of natory or other place	a)	D	ate	20c. Locatio	n - City or	Town, State	
Ĕ	Page ment ant: I ury o				eph's		3/31/	/2011 N	lorgan	za, M	laryland	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be for Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic esonce.		21. Signature of Funeral Service Liverage	22	Name and Addres. Matti P.O.	s of Facility ng Ley Box	y-Gar 270	diner I	unera Itown.	l Hom Marv	ne, P.A. land 20650	
			23a. Part I. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente							Approximate	
-	nysician/		Immediate Cause (Final disease or condition	ni f	Dulia.						Interval Between Onset and Death	
	Medical Examiner		resulting in death)  Due to (or a a consequence	e el:	O							
		<u>.</u>	Sequentially list conditions, b.	0 H	ine							
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or linjury	e of):								
	ecute and Il-tran	Exal	that initiated events resulting in death) Last  C. Due to (or as a consequence	e of):			-					
2	te be executed hysician and he burial-transit	dical	L <sub>a</sub>									
2/60	ficate g phy as the	<b>Nedi</b>										
200	n certifica ending pl	Physician/Me	IF FEMALE: 23b. Was decedent premant 1 □ Live Birth 2 □ Fetal de		Ectopic pregnancy	,			23d. l	Date of de	livery	
Rox	death he atte ed for	sici	in the past 12 pponths?		Other (specify)				1	Month	Day Year	
o '	at the d by ti etach		Part II. Other significant conditions contributing to death but not resultin	a in the u	ndarlying cause give	on in Dart I		00- Did 4-1		Andrille Laker Are	the cause of death?	
7.	es tha	d by	Tarkin Galar Significant Goldans Control State (Control of the Control of the Con	ig in the di	nderlying badse give	SITTITE COLOR.		1 🗆 Y	/		robably 4 Unknown	
ğ	requir	etec										
Records,	e law has b ge 2 s	Completed				_		24a. Was a autops perfore	sy 🖊	prior to death?	topsy findings available completion of cause of	
ř	n: The		25. Was case referred to medical		00 DI-		· (Ot1-	1 Tyes	2 No	1 🗌 Yes	s 2 No	
Vita	rsicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpotion	Othor	ce of Death		ne 5 🗆 Reside		Ab /O		
0	g Phy erthis neral c		27. Manner of Death 28a. Date of injury 28b	o. Time of	28c. Injury	at		8d. Describe ho			ery)	
0	endin sath. or: Aft oe fur	ficat	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	M 1 □ Y	yes 2□	No					
DIVISION	or Atter de irecto	Certificate:	3	farm, stre	et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
5	pital o											
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier  ├── Certifying Physician: To the best of my knowledge  (Check 2	d/or investi	igation, in my opinior	n, death occ	curred at t	he time, date an	d place, and	due to the	cause(s) and manner stated.	
:	To the withir	2	29b. Signature and title of certifier	owicage, a	29c. License		and place		9d. Date sign			
			Monden John		10	709	00		8/28	411		
			30. Name and address of person who completed cause of death (Item 23a	a) (Type, P	rint)	,			-1	0.10	1	
ىلە			2007 Tidewoler Money	11/_	Puite 1	AI	Ann	apolis	ma	214	0	
	Stat Registra	_	31. Date filed (Month, Day, Year)  AUG 3 0 2011  32. Registrar's Signature	1	excel	,		0				
			MUU DI U CUITI APPROPRIA		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a per med cert 6919 9/13/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Mary Luster U6US Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** A PLATA MEDIC ('ENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Month, Day, Year) 1930 1 □ M 2 🙀 F Months Hours Month, L November Country) New Mexico 525-66-9342 80 Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c City Town or Location 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 😾 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? injury or other traumatic event, the Medical Examiner must be Funeral items 23a 70 Village Street, Apt. 415 20602 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important if item 27 is marked other any injury or other traumers. Black White etc. 1 Never Married 2 Married Completed by 1 X Yes 2 No Specify: Spanish White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Los Alamos National Elementary/Seconday (0-12) College (1-4 or 5+) Travel Claims Processor Labratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maclovio Gonzales Clara Trujillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Luster/Son 3055 Catawba Court, Waldorf,MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Brinsfield-Echols Crem. 8/23/2011 1 Burial 2 Cremation 3 Removal from State Charlotte Hall, MD 4 Donation 5 Other (Specify) Signature of Euneral Service L M01458 22. Nararehari echols funeral home, P.A. 20646 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year page 2 should be detached it 1 ☐ Yes 2 ₹ 9 ☐ Unknown the signed by Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? à Records, The law requires 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 2 **X**N Yes Vital To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? 2**%** No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this of funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending Division 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2 011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahhas A. Dmais MD 7-C Post of 2(3)2 A. Omais 31. Date filed (Month, Day, Year) 32. Reg strar's Signature State AUG 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#29c,29d,per Dr.,QACHD,ms,8/24/2011 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VICTOR HERBERT LANEHART 18 2011 2017 M AUGUST Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial HOSPItal EASTON TAIDOT If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 75 213-34-7287 10/107/11935 PENNSYLVANIA **Director** Usual Residence of Decedent show 10a. State 10b. County hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD QUEEN ANNE'S 1 Yes 2 X No QUEENSTOWN 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Victo Funeral "natural", or items 23a 7004 MAIN STREET 21658 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GROUNDS KEEPER LANDSCAPING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ OWEN A. LANEHART MARY LENA PITTMAN 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is, any injury or other traunonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE L. HARRIS / SISTER 213 FEDERAL ST., SNOW HILL, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State CHESAPEAKE CREMATION CENTER 4 ☐ Donation 5 ☐ Other (Specify) 08/22/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as by the attending IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Petal death 3 Ectopic pregna
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ò in the past 12 months? Month Day signed by the ar Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 100 မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be

To the Hospital o within 24 hours af To the Funeral Di completed filled ir

Medical

Homicide

29a. Certifier

(Check only one 29b. Signature

determined

who completed cause of death (Item 23a) (Type, Print) 219 Soutz (Month, Day, Year) AUG 2 4 2011 32. Registrar's Signature State Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0065656

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

AUGUST 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth A. Logeman August 19, 201<sup>T</sup> 6:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19304 Tattershall Drive Germantown Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗓 F Months Davs Hours Min. Sept. 23 Pennsylvania 180-09-7576 Director 93 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 💢 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 19304 Tattershall Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? or i Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Year or Dates White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home should be filed w and Mental Hygi is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irvin В. Sho11 Martha Deitz 1 and 2 should be of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19304 Tattershall Drive, <u> Gary Logeman - Son</u> Germantown, Maryland or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Mem. Gdns. 8/26/11 | Columbia, Pennsylvania 21. Signatur, of Fune al Service License Molesworth-Williams P.A., Funeral Home Lovert 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-transi Chronic Renal Insufficiency that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 Chronic Obstructive Pulmonary Disease as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 No the 9 Unknown ò s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform death? this certificate Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending □ Accident
□ Suic n 24 hours after death.

e Funeral Director: A leted filled in by the fu 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 A Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check Certifying Nurse Practioner: To the best of my knowledg dat the time, date and place, and due to the causels) and 29b. Signature and title of certifier GarlinDI 29c. License number 29d. Date signed (Month, Day, Year) D 41162 August 20, 2011 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Vinu Ganti,

31. Date filed (Mon:

M.D.

egistrar's Signature

19529 Doctor's Drive, Germantown, Maryland 20876

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 27, 2011 7:00 p.M. Dean Mercure Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's 50237 Hays Beach Road Scotland | 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min Maryland **Director** 78 1932 217-32-2137 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No <u>Maryland</u> St. Mary's Scotland 5 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 50237 Hays Beach Road 20687 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

XYes 2 \( \subseteq \text{No.} \) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည John Nelson Dean Edith Rebecca Ridgell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Mercure/Son 50237 Hays Beach Road, Scotland, MD 20687 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2  $\square$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Michael's Cem. 9-01-2011 Ridge, MD 22. Name and Address of Facility
Brinsfield Funeral Home, 21. Signature of Funeral Service License Danielle Ward M01403 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Carela disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to limit cause. Enter Underlying Examir The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗶 No Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work n 24 hours after death.

e Funeral Director: Aft elleted filled in by the fur 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотрыете Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certif 14285 8-30-11

State Registrar William

D.

Boyd

DHMH 17 Rev 7/2009

25365 Point Lookout Road Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

II,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	epartment of Health an		ene g. N2 0 1 1	28674						
	Physicia		1. Decedent's Name (First, Middle, Last) Blanche M. McCusker		2. Date of Death August	24, 201 <sup>r</sup>	3. Time of Death <b>7:50</b> P M						
	Medic Examin		4a. Facility Name (if not institution, give street and number) 2310 Wintergreen Ave.	4b. City, Town, or Location of District Heigh	Death ts	4c. County of Death Prince Geo	rge's						
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 63 Yr	Months Days Hours N	Hrs. 8, Date of Birth  Min. Feb. 22	9. Birthr (ear) 1948 Mass	sachusetts						
	yland f show ed at	ctor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town o			1	0d. Inside City Limits						
	the Mar a or 28a- be notifi	al Director	10e. Street and Number	Heights  10f. Zip Code	10	g. Citizen of What Cour	1 Ves 2 No						
	eath witl tems 23 er must	Funeral	4132 Urn St.  11. Marital Status  12. Was Decedent Ever in U.S.	20743  13. Was Decedent of Hispanic Origin; If Yes, specify Cuban, Mexican, Pr	? (Specify Yes or No-	USA							
9800	urs after d tural", or i al Examin	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 No Specify:	uerto Hican, etc.)	Black, White, White, Specify:	etc. e						
Baltimore, Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland ad Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of e. DO NOT use retired) tender	f working 1	eb. Kind of Business Inc Leet Reser Restaurant							
land	should be filed v and Mental Hyg <b>is marked othe</b> <b>raumatic event</b> ,	To Be	17. Father's Name (First, Middle, Last)  John Arthur McCusker	18. Mother's Cecil	Name (First, Middle, Ma Le Beatrice								
Mary	12 should lith and N 27 is ma		,	Mailing Address (Street and Number of		•							
more,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once,		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery,	isposition (Name of crematory or other place)	Date 2	Oc. Location - City or To	wn, State						
Baltii	permit. P Departm Importar any injur		21. Signatur Funeral Service Licensee	22. Name and Address of Facility G	George P. Ka	las Funera	1 Home, P.A.						
			23a. Ran 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death						
	Pnysician/ Medical Examiner		disease or condition resulting in death)  Lung Cancer  Due to (or as a consequence of):										
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):										
	e execute cian and ourial-trans	dical Exar	that initiated events c. Due to (or as a consequence of):										
68760	tificate b ng physi as the b	Medic	d										
Box 6	law requires that the death certificate be executed ras been signed by the attending physician and 2 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ery Day Year						
s, P.O.	ires that th signed by d be detac	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4 Unknow										
Vital Records,	ician: The law requi certificate has been rector, page 2 should	Completed			24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of						
Ital F	ysician: Tl is certificat director, pi	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	26. Place of Death (	(Check only one)	Sister	s kesidenc						
101	ling Phy T. After this funeral d	ate: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) inju	e of 28c. Injury at work?	ing Home 5 Residen  28d. Describe how								
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No , street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
_	e Hospita 24 hours e Funeral bleted filled	Medical											
	To the within to the comp	<	29b. Signature and title of certifier  MS Ny apalne MD	29c. License number 0 00 5 7 4	29	d. Date signed (Month,							
	81		30. Name and address of person who completed cause of death (Item 23a) (Tyr N.S. Rajapakse, M.D. 2835 Smith Av	pe. Print)			·						
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature		-, 2120								
			TOUR OF MANY OF THE WAY										

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Ritá Ghosh, M.D. 14812 Physicians Ln., #161, Rockville, MD 20850

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28676 Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Physician/ BARBARA DRUMMOND MEAD AUGUST 2Š 2011 12:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours Director 218-78-0725 1 M 2 XF 51 10/28/1959 MARYLAND 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2X No MD QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 532 CROSS CREEK COURT 21619 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Inforcant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PUBLISHING 12 4 PUBLISHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ANTHONY DRUMMOND DOROTHY BULLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 532 CROSS CREEK COURT, CHESTER, MD 21619 CHARLES F. MEAD / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 08/24/2011 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Intracevebrel disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to himselfate cause. Enter Underlying Cause (Disease or injury Examiner Day to for os o cursacuence of: g physician and as the burial-transit Arteriovenou that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 9 Unknown P.O. ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, The law requires 1 🗌 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 2 🗌 No Yes 2 N 1 🗌 Yes the Hospital or Attending Physician; Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျ 1 Impatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifie Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I comple only one 29b. Signature and title 29d. Date signed (Month, Day, Year) ٥ D00012329-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY DaWARD V 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 24

DHMH 17 Rev 06-2011

Registrar

A. park

11-06456 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 28677 Neal McElhaney, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 27, 2011 0710 hrs **Medical Examiner** NEAL REX MCELHANEY, SR. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Charles 6885 Annapolis Woods Road 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Hours Director 572-28-3952 11-20-1926  $_{1}X_{M}$ 84 Country) CA. 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits uny 10a, State 10b. County 1 Yes 2 No or 28a-f show MD. CHARLES rmit. Pages I and 2 should be filed within 72 hours after death with the Maryland ppartnent of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at once. LA PLATA Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 6885 ANNAPOLIS WOODS ROAD 20646 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. NAVY 1X Yes Specify: WHITE WWII If Yes, Give Yeer or Dates: 1 Yes 2 No specify: 3 Widowed 4 Divorced é 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 RET. CHIEF PETTY OFFICER 12 U.S.NAVY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NEAL REX MCELHANEY DOROTHY MARIE DENNIS 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ LOTTIE McELHANEY-SPOUSE 6885 ANNAPOLIS WOODS RD. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, Date crematory or other place) 1 Burial 2 XCremation 3 Removal from State ATLANTIC CREMATORY 9 - 1 - 11GLEN BURNIE, MD. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Intraoral Gunshot Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit cian/Medical g physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending por use as the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? funeral director, page Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject shot self 1 Natural **FOUND** 1 Yes 2 ✔ No Pending hours after death. Funeral Director: tely filled in by the Aug 27, 2011 0700 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 6885 Annapolis Woods Road, La Plata, MD determined At home Homicide 29a. Certifier 1 Certifying Physician: To the jest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. August 28, 2011 30. Name and address of p son who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner OCME 900 W. Baltimore Street, Baltimore, MD 21223 Date filed (Mo 8 32. Registr 's Signature State P Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28678 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 AM August 7:19 ANNE PIECH MOSER NANCY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Indiana 1 🗆 M 2 💢 F Months Days Hours Min. Director 58 April 953 311-52-8860 Usual Residence of Decedent or 28a-f show 10b County 10d. Inside City Limits Ħ 10a. State 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2X No Middletown Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 23a Funeral United States 21769 4518 Old National Pike or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3 Widowed 4 XDivorced Completed Vear or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Medical Research Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Frank Thomas Piech Anne M. Beyer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3524 Fellows Street, South Bend, Indiana 46614 Lesa <u>A Piech / Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Southlawn Cemetery 1. 2011 South Bend, Indiana 21. Signature of Funeral Service Ligensee Keeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 MO1473 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Ph, i ian/ Hypoxemiz disease or condition Medical resulting in death) **Examiner** hable enmonta ONE 53quartially list concilions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events mona Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death detached 9 Unknown 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 X No 1 Yes 1 XInpatient 2 - ER/Outpatient 3 -ည 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗐 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [ only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 2011 26 MDD 35106 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Hee Nom 7th St Frederick , mo 21701 400 1. Date filed (Month, Day, Year) 32. Registrar's Si

Registrar

SFP 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGth 28, 2011 VIOLET BAYNE McDONALD 6:25A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST.MARY'S CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Months Days Hours 410nth 7ay, Year 23 N Country) 579-40-3860 88 Director Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11060 WEYMOUTH COURT U.S.A. 20603 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No NAVY Black White etc 1 Never Married 2 Married þ Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates WWII 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 9 FOSTER JAY DELANEY MARION ESTELLE BRADLEY permit. Page 1 and 2 should be Department of Health and Mern Important; If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ER 2028 TANGLEWOOD DR • WALDORF, MD • 20601 19a. Informant's Name/Relationship (Type, Print) MAUREEN A. PHILLIPS-DAUGHT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD TETERANS THE CEM. 9 - 6 - 11CHELTENHAM, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Gequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): and I-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes 2 1 No 3 Probably 4 Unknown as been signal 24b. Were autopsy findings available 24a, Was an has autopsy prior to completion of cause of certificate ha irector, page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to edical æ 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 **1** No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu death. 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Murical Examiner: On the basis of examination and/or inv tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Norse Practioner To the Sest of my know death occurred at the time, data and place, and due to the ca 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Ite

31. Date filed (Month, Day, Year)

SEP 0 8 2011

DHMH 17 Rev 7/2009

32. Registrar's Signature

11-06348

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Roger Piper, Jr. 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day August 23, 2011 Medical Examiner Roger Dale Piper Jr. 1114 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Allegany 15819 McMullan Highway Apt. D2 Cresaptown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country)/// Months Days Hours Director Sep 8, 1971 215-94-8651 1 MM 2 F 39 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No 28a-f show MD Allegany Cresaptown notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14216 Cunningham Dr. SW 21502 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: white 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 disabled <u>n</u>/a 18.Mother's Name (First, Middle, Maiden Surname) Be Roger Dale Piper, Sr 19a. Informant's ame/Relationship (Type, Print) Debra Davidson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic MD 21502 14216 Cunningham Dr. Debra Oates mother Cresaptown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State ment o 8/25/2011 MD 4 Donation 5 Other Specify: Scarpelli Funeral Home, P.A Cresaptown Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Part I. Enter the disease/ or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Modical a Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. signed by the attending physician and be detached for use as the bunal - trar Physician/Medical AMENDED 23a,27,per me,g920 10-25-11 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been s funeral director, page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes No 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: within 24 hours after deau..

To the Funeral Director: Af 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 24, 2011 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

**OCME 2006** 

SEP 0 8 2011

32. Regiarar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28681 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:25 p M Renee 2011 Rhonda Ross August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth **Funeral** Days July 22, 1968 1 M 2 F Months Hours Kentucky 43 215-08-5054 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 No Lexington Park St. Mary's Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19599 Point Lookout Road 20653 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give Specify: 3 - Widowed 4 - Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trainer Horses Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Samuel Eckler Donna Monohon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 19599 Point Lookout Road Leonardtown, MD 20650 Robert T. Ross / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State St. Andrew's Cem. 9/08/2011 4 ☐ Donation 5 ☐ Other (Specify) California, Maryland 21. Signature of Funeral Service Licens le 22. Name and Address of Facility Brinsfield Funeral Home, P.A. mis Danielle Ward M01403 22955 Hollywood Road Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ventricular standstill Jecondary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner stage renal Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Dire to fur as a consequence of Diubety relitors that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 A No Month Day Vear Pregnant at time of death 9 Unknown 9 Unknown ed by t detach s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Registrar

DHMH 17 Rev 7/2009

State

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Lari Rainhart

SEP 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St Mary's Hospital

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

C. - Box

29c. License number

D0068540

524

Leonarditorn

29d. Date signed (Month, Day, Year)

august 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 30 per DVR, e919 9-8-11 sm State of Maryland / Department of Health and Mental Hygien () State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ,<sup>Day</sup> 2011 Physician/ AUG.25 BERNARD WILLIAM RYON 11:34A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FT.WASHINGTON HOSPITAL FT.WASHINGTON P.G. . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 35 WASH., D.C. 1 XM 2 🗆 218-30-4866 76 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director PRINCE GEORGES 1 Yes 2 No MD. ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 16704 HURON STREET 20607 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1X Yes 2 No NAVY Black, White, etc. ò 1 Never Married 2 X Married by Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: Specify: WHITE Year or Dates. KOREA "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. NAVAL RESEARCH Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 12 4 ELECTRICAL ENGINEER LAB other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM EDWARD RYON, SR. PAULINE HOLSINGER permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic ss (Street and Number or Rural Route Number, City or Town, State, Zip Code)  ${\tt HIRON\ ST\_ACCOKEEK,MD}_{ullet}\ 20607$ 19a. Informant's Name/Relationship (Type, Print) BETTY A. RYON-SPOUSE 16704 HURON ST. ACCOKEEK, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State MD° VETERANS th CEM. 9-6-11 CHELTENHAM, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Faci RAYMOND FUN LA PLATA, MA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause of each line. Approximate interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner Ecquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or Exami and Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Yes 2 No ed by the a 9 🗌 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🍂 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?\*
1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work's 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00531

Registrar

State

31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

Bark

32. Registrar's Signature

11711 Livingston Rd. Fort Washington, MD, 22003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28683 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2011 Pay Physician/ Aug 22 7:30 A Douglas Reynolds В. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2806 Rose Valley Drive Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** May 23, 1943 Days 1 ★ M 2 □ F Laurel. MD Director 68 214 42 4779 Usual Residence of Decedent tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Fort Washington Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20744 United States 2806 Rose Valley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 XXMarried Yes 2 No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1961-1964 Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Prince George's County Police Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental F is marked of မ Jacqueline Davis permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic & Leslie A. Reynolds traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Reynolds (Wife) 2806 Rose Valley Drive, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD Maryland Veterans Cemetery 8-29-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Tome, Inc. 6633 Old Alexaniria 21. Signature of Funeral Service Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months? Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the upon 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: မှ 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA completed filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work' 1 ☐ Yes 2 ☐ No М Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyme Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar te filed (Month, Day, Year)

7.Biot

to completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28684 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August 2011 12:06 P M BONNIE L RITTER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 16, 1923 Months Days Hours Min. 520-20-1599 Wyoming Director 87 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Maryland Frederick Burkittsville 1X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 East Main Street U.S.A. 21718 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after white 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene.  $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) cosmetic sales person drug store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Phillips Bona Margaret Joy Brock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 David L Ritter - son 20403 Jefferson Blvd. Hagerstown, Md. 21742 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or ourself present Cedar Lawn Memorial Park 1 M Burial 2 Cremation 3 Removal from State Aug. Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Ceronaru disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No jo Month Dav Year 1 Yes 2 been signed by the sahould be detached 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 \sum Yes 2 \sum No safter death.

I Director: Affine by the fu ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 02 CA 31. Date filed (Mo State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien = State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28 2011 3:20  $A^{M}$ August Larry Scott Stewart Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Callaway St. Mary's Hospice House of St. Mary's If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Yea 1 **X** M 2 □ F Days Hours Min (ear) Pennsylvania Months Oct. 1961 Director 205-52-0829 49 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ within 72 hours after death with the Maryland Director items 23a or 28a-f s per must be notified 1 Yes 2 X No Maryland St. Mary's Hollywood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23141 Hollins 20636 U.S.A. Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. ٥, 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: er than "natural", or the Medical Exan If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 4 Program Management U.S. Government Ith and Mental Hygie 27 is marked other r traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မ Kar1 Stewart Sharon Wimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23141 Hollins Way Hollywood Maryland 20636 Diana Lynn Stewart / Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-31-2011 Charlotte Hall, MD Brinsfield - Echols Kathleen Santivasci M008 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00872 22955 Hollywood Road Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner months. Metastatic Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death P.O. ed by the been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has page 2 s autopsy performed? Yes 2 X No prior to completion of cause of death?
1 ☐ Yes 2 🗶 No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice House examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death.

the Funeral Director: After thi

npleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 🚣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 3 within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 68846 September 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POINT LOKOUT Rd, Leonardtown, MD-20650 25500 ST. MARY'S HOSPITAL, KHAN, M.)

Registrar

State

Registrar's Signatur

SEP 0 1 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 28586 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar	Death	Reg.	No.					
Physicia	n/	Decedent's Name (First, Middle, Last)		Date of Death     Month	ay Year	3. Time of Death 0125 hrs				
edical Examin		Johathon Joel Bhydel	o. City, Town, or Location of Death	August 27, 2	4c. County of Death					
)		4a. Facility Name (if not institution, give street and number)  4b. Dorsey Park Wooded area	Hollywood		St. Mary's					
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	curity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YY							
Director		220-06-3696 1XM 2 F 27 Yrs.	-3696 1XM 2 F 27 Yrs. Months Days Hours Min. May 14, 1984							
	-	Usual Residence of Decedent	<u> </u>	Inay 14	1904   110	aryland				
v any		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits  1 Yes 2 X No				
Maryland 28a-f show d at once.	ō	Maryland St. Mary's Hollywood		1.0						
Mary	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	itry?				
death with the Maryland or items 23a or 28a-f sho must be notified at once.		24992 Sotterley Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	20636  Decedent of Hispanic Origin? ( S	pecify Yes or No-	U.S.A.	can Indian, Black,				
ath wi	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s, specify Cuban, Mexican, Puerto		White, etc.					
		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: Whi	te				
ours a	ğ Ş	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's during mo	s Usual Occupation (Give kind of st of working life. DO NOT use ret		6b. Kind of Business/					
6 172 h	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	•							
within spiene.	Completed	12 Truck	Driver 18 Mother's Name	e (First, Middle, Ma	Wells					
11215-0036 Id be filed within 72 hours after femal Hygiene. arriced other than "natural", event, the Medical Examiner.	Be C	Armando Vicente		nn Baile						
212 ould be Ment mark		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing	Address (Street and Number or			, Zip Code)				
MD 12 sho			Sotterley Road							
Fe, land f. Heal		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposit crematory or other	ion (Name of cemetery, er place)	Date	20c. Location - City or	Town, State				
Pages nent o		Donation 5 Other Specify: Charles Me	m. Gardens 9-	2-2011	Leonardt	own, MD				
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er	Ī	21. Figure of Funeral Sant Licensee 22. Na	Funeral Ho							
		Kathleen Santivasci M00872 229  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	55 Hollywood Ro	ad Leonar	t. shock, or heart	20650 Approximate Interval				
Physician Medical		failure. List only one cause on each line.				Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence of):								
	.	Sequentially list conditions, b.				-				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause c.  Due to (or as a consequence of): c.								
	xam	(Claims or injury that initiated events resulting in death) Last Due to (or as a consequence of):				1				
' <b>60,</b> rate be executed ohysician and re burial - transit		d.  X UNPENDED AMENDED23a,27,28a-f,pe	020 10 25	11 cm						
'60, zate be ex physician he bunial	Medical	▼ UNPENDED		-11 SM	23d. Date of deliver	<u> </u>				
			al death 3 Ectopic pregn	ancy		Day Year				
Box 687 death certific the attending p	Sicia	4 Pregnant at time of death 5 Oth	er (Specify)			l.				
0 77	Physician/	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?				
ires that the signed by	Š			1 Yes	2 No 3 Pro	bably 4 🗹 Unknown				
ords, w require s been si should b	Completed			24a. Was an		utopsy findings available completion of cause of				
Records, The law require ficate has been si	E E			autopsy perform	ned? death?					
tal Re			26.Place of Death (Check		INC IV	2 1.0				
of Vital ng Physician: After this certi	To Be	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nursi	ng Home 5 R	esidence 6 🗸 Othe	r: Scene				
ing Ph	盲	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of In		1	w injury occurred	ı£				
ttendi ttendi death.	atio	Natural 5 Pending Investigation Fd 8-27-11 Fd 1:25		1.11	hanged sel					
Division tal or Attendi rs after death. al Director: A	Certification:	3 X Suicide 6 Could not be determined (Specify) wooded are			nte) Dorsey Pa	ural Route Number, City				
Ospital hours a uneral ]										
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred	at the time, date ar	nd place, and due to the	ne cause(s)				
To To con	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)				
		The MI KATA	O.C.M.E. 00	ME	August 27, 2011					
		30. Name and address of person who completed deuse of death (Item 23a)	2014 5		04000					
		Theodore M. King, Jr., MD. Assistant Medical Examiner		saitimore, MD	21223					
St	ate									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:55 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🗙 F VIRGINIA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he matified at ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Funeral Director 1 🗌 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DEPART MENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State . Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the s completed filled in by the funeral director, page 2 should be detached it 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed Venous insufficiency 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONIALWas 31. Date filed (Month, Day, Year) State SEP 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State 28688 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evelyn Ruth Sharer 19, 8:06 A M August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington Williamsport 15429 Clear Spring Road 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number **Funeral** (Month, Day, Ye April 3, Year) 1927 Hours 1 □ M 2 🎗 F 84 Director 216-22-7980 Maryland Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Washington Williamsport Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral USA 21795 15429 Clear Spring Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black White etc. 1 Never Married 2 X Married ☐ Yes 2 🛛 No þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes. Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Worker Nursing Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Faulders Benjamin t. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williamsport, MD 21795 15429 Clear Spring Road Ezra C. Sharer - Husband Baltimore, 1 D Bural 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Cedar Lawn Mem. Park 08-22-2011 Hagerstown, Maryland Conation 5 Other (Spe 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 nature of Juneral S Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ VPCI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine sician and burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown the Hospital or Attending Physician: The law requires 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of macrocy tosis 24a. Was an death? performe 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 No n 24 hours after death e Funeral Director: A bleted filled in by the fi Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print JW-6

Registrar DHMH 17 Rev 7/2009

State

**E**istrar's Signature

EN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 8:00A M Raymond Frederick Symonds 08 28 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington 14615 Pennersville Rd. Cascade If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 ☐ F Yrs 08 21 1929 East Boston, MA Director 010-22-8607 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State or other traumatic event, the Medical Evaniner must be notified at 1 □Yes 2 XNo **Funeral Director** MD Washington Cascade 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US 14615 Pennersville Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status If Yes 2 No. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white δ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) federal government soldier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola M. Nickerson Raymond Symonds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 is any injury or other trau once. P.O. Box 239 Cascade, MD 21719 Glenys L. Symonds 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2/2011 Bethel Church Cem. Cascade, MD 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Fune Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PA 17268 Approximate interval Between Onset and Death 23a. Part 1. Enty the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation neral Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) and manner stated. 0036009 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05 00 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

501

Dagen

31. Date filed (Month, Day,

SEP 0 8 2011

Waynesboro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene 20   28690																	
		I- For State Registrar	(5)			(	Certifi	icate of	Deat	h				Reg. No	).		
Physician Medical Examine	er	1. Decedent's Nam Richai	rd		Emerso		S	weitze					Date of D Month August	Day 22, 20		3. Time of Dea 0850 hrs	
		4a. Facility Name ( Western Ma		. •		mber) 4b. City, Town, or Location of Death  Cumberland							c. County of Deatl Allegany				
Funeral Director		5. Social Security N 215-58-6		6. Sex	A 2 F	7. Age (In y	yrs. last b	oirthday) Yrs	Month	s Day			8. Date of Sep		951 9. Bir		ır
any		Usual Residence o 10a. State	f Decedent 10b. County			10c.	10c. City, Town or Location							10d. Inside City Lin			
	ا ا	MD	A	llega	any		•		nberl	and						1 X Yes 2	No No
igg the		10e. Street and Nu 223 E							10f. Zip	Code	215	502		10g. Ci	tizen of What Cou US		
r death with or items 23 must be no	uneral	11. Marital Status 1 X Never Marri	ed 2 M	larried	12. Was Dece Armed For 1 Yes						spanic Orig n, Mexican,			No-	14. Race - Amer White, etc.		ck,
s after ural", o	6	3 Widowed  15. Decedent's Ed			Yes, Give Year or Dates:			1 Deceden			specify:	kind of wo	rk done	Iseh	Specify: Wh		
5-0036 led within 72 hours after Hygiene authorition to other than "natural", the Medical Examiner Commissed by		Elementary/Seco			College (1-		102	during m	ost of wor	king life	e. DO NOT			100.			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than r event, the Medica	5	17. Father's Name	(First, Middle	, Last)				auto	mec	nanı	18.Mother	's Name (I	First, Middle	e, Maider	self-emp n Surname)	loyed	
1214 d be fill lental H arked event, i		Har	vey Sw	<u>eitze</u>	<u>er</u>		- 12	10) M-10-	A 11	101		Clara	Simr	ns			
MD 21 and 2 should alth and Me m 27 is ma aumatic er		Shelle	y Swei	itzer	e, Print )	daugl	hter	45	0 Wi	lian	ns Str	eet	(	Cumb	City or Town, State Derland	MD 21	1502
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		20a. Method of Dis 1 Burial 2 4 Donation 5		_	Removal from	n State	crem	e of Dispos latory or oth Je Cem	er place)		ernetery,		Date 8/26/201		Swanton		MD
Balti permit. Departm Imports		21. Signature of Fu	neral Service	License				22. N	ame and	Scarp	s of Facility Delli Fun	neral H				•	
Physician	1	23a. Part I. Enter th				used the de	eath. Do	not enter th	ne mode o	108 \ of dying	/irginia , such as ca	Avenu ardiac or r	espiratory	oerlan arrest, sh	d, MD 21502 nock, or heart	Approximate Between On	
/Medical Examiner		Immediate Cause ( or condition resulting			therosclero ue to (or as a c			ular Dise	ease							Deat	h
100	2	Sequentially list co if any, leading to in cause. Enter Unde	nmediate	b	ue to (oras a c	consequen	ce of):										
ecuted and transit	EXALI	(Disease or injury t events resulting in	hat initiated	c. Du	ue to (or as a c	onsequen	ce of):										
e execut cian and irial - tran	3	UNPENDED		7	AMENDED												
b. Box 68760, the death certificate be except the attending physician ched for use as the burial-Physician/Medic		IF FEMALE: 3b. Was decedent past 12 months	5?		' = '	th nt at time o		2 Fet	al death ner (Spec	3 cify)	Ectopic	pregnand	;y	23	3d. Date of deliver Month [		ear
t the dex by the 2 ached fo		Part li. Other signi			9 Unknow ontributing to d		not result	ing in the u	nderlying	cause	given in Par	rt I.	23e. Dic	tobacco	use contribute to	the cause of de	ath?
S, P.O. puires that the signed by lid be detach	פת הא	Chronic ald	cohol abus	e									1 🗸 Y		No 3 Prot		
Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death as fire death.  **A Director: After this certificate has been signed by the atterled in by the funeral director, page 2 should be detached for untilication: To Be Committed by Physic												_	aut	opsy form <u>ed</u> ?	prior to death?	topsy findings a completion of ca	
		25. Was case reference examiner?	red to medica		spital:	patient 2	ED/	Outpatient		26.Place	of Death (	Check on Nursing		Docid	ence 6 Other		
ing Phys After this funeral di	-  -	1 ✓ Yes 27. Manner of Deat 1 ✓ Natural			28a, Date of (Month, D	f Injury		o. Time of Ir		28c. Inju	iry at Work	? 2			jury occurred	<u> </u>	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificantle ompletely filled in by the funeral director, ledical Certification: To Be (	T and	2 Accident 3 Suicide		ding stigation d not be	28e. Place	of Injury - /	At home,	farm, stree	t, factory		Yes 2		8f. Location or Town		and Number or Ru	ral Route Numb	er, City
		4 Homicide 29a. Certifier 1 (Check only		rmined hysician	(Specify)	of my know	vledge, d	leath occur	ed at the	time, d	ate and pla	ce, and di	·		nd manner as stat	ed	
To the Ho within 24 To the Fu completel	2	one) 2 🗹		a	n the basis of nd manner sta		on and/o	r investigati				curred at t	he time, da		ace, and due to th		
0 34		29b. Signature and	title of certifie	er 1	11	5	7	7	290	O.C.	M.E.				Date signed (Mo. gust 23, 2011	nth, Day, Year)	
- ','	1	30. Name and addr Zabiullah Al			mpleted cause ant Medica	i		·	altimor	e Stre	et, Baltir	more, N	ID 2122:	3			
State	e (	31. Dåtë filed (Mont	th, Day, Year)	has	32. Reg	ister's Sig	inditure	N									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan		rtment of		and M	,	2 0		28691
			Registrar  1. Decedent's Name (First, Middle, Last)	)		Cer	uncate or	Deain		2. Date of Dea	Reg. No.	1 1	3. Time of Death
	Physicia Medic		A1b	ert Urie	Star	tt. Sr.				August	<sup>D</sup> 26	$2 \overset{Xear}{0} 1$	0825 A™
	Examin		4a. Facility Name (if not institution, give s		-		4b. City, Town,		of Death		4c. Coun	ty of Death	
			216 Sycamore Road  5. Social Security Number 6. Sex		- //		E1kto		- 04 Ura			eci1	
	Funeral Director			V	je (in yrs. iz 73	ast birthday) Yrs.	Months Days		Min.	8. Date of Birth OCT 31	Year) 1937	9. Birthi Coun Ma	place (State or Foreign htry) ryland
Р	t t	_	Usual Residence of Decedent  10a. State 10b. County			y, Town or Loc	ation						10d. Inside City Limits
arylan	a-f shified	Funeral Director	Maryland Cecil		1	Lkton	ation						1 ☐ Yes 2 👿 No
the M	or 28 e not	١	10e. Street and Number		1 11	LKLOII	10f. Zip Code				10g. Citizen o	f What Cour	
with r	is 23a nust b	Jera	216 Sycamore Road				2192	.1			Unit	ed St	ates
death	r item iner n		THE THE TENED	12. Was Decedent E Armed Forces? 1 ፟፟፟፝ Yes 2 ☐	Ever in U.S		as Decedent of I Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		ace - Americ ack, White,	
<b>036</b> s after	ral", o Exam	Completed by	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 M Yes 2 ☐ If Yes, Give Year or Dates.	No 196	2 1	☐ Yes 2 🗓 N	Specify	<i>'</i> :		Specia	4	ite
<b>5-0</b>	"natu	plete	15. Decedent's Edu (Specify only highest grad	ucation			ent's Usual Occu ind of work done		et of workin	ng I	16b. Kind of		
<b>127</b> thin 73	than than	Som	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DC	NOT use retired	)		<i>'</i> 9	Por	nking	
	Hygie other	Be	17. Father's Name (First, Middle, Last)			110	HOLIOIS			e (First, Middle, I			-
<b>/lan</b> dbe f	Menta arked atic ev	욘	William Howard St	artt				Mar	y Rho	oades			
Mar.	h and 7 is m traum		19a. Informant's Name/Relationship (Typ			1	g Address (Street				-	_	Code)
Baltimore, Maryland 21215-0036 Jermit. Page 1 and 2 should be filed within 72 hours after	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		M. Adelaide Mahan  20a. Method of Disposition		20b. P	lace of Dispos	Sycamore sition (Name of				2192 20c. Location		own, State
mo Page	ant: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ F				atory or other pla	Inc.	Septe	ember 011		-	ter, PA
Salt erait.	nporta ny inju		21. Signature of Funeral Service License	е		22.	Name and Addre	ess of Facili	ity Hic	cks Home	e for F	unera	ls, F.A.
<b>ப</b> வ			23a. Part 1. Enter the disease, or compli	ications that causes	h D	Do not onto				Street,		n, MU	
~ Dh	sician/		shock, or heart failure. List only one Immediate Cause (Final	cause on each line	e.			4			551,		Approximate Interval Between Onset and Death
1	Medical		disease or condition resulting in death)	Due to (or as a	a consequ	ience of):	eptic 1 Cano	3000	CVC			-	_
E)	kaminer	ŗ.	Sequentially list conditions,	). <del></del>			r Cano	er c	M	ets			
pe	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	ience of);							
execut	an and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	a consequ	ience of):	·						
S ate be	hysicia the bur	edical		d									
oo/	ding p		IF FEMALE: 23b. Was decedent pregnant	3c. If <u>ye</u> s, outcome	of pregnar	ncy					004 5		
<b>BOX</b>	e atten d for u	Physician/M	in the past 12 months?	1 Live Birth 4 Pregnant a	2 Fetal	Ideath 3 🗌	Ectopic pregnant Other (specify)	су				ate of delive nonth	ery Day Year
that the	by the	Phys	g Unknown	9 Unknown		Jain - In ab		i an la Dard		I			
res the	signed If be de	d by	Part II. Other significant conditions con	Circuit of the death of	at not rest	uiting in the di	idenying cause g	iven in Pari	. 1.				ne cause of death?
Hecords, The law requires	s been shoul	lete	HT	N					-	24a. Was a		. Were autor	psy findings available
Tec	ate has page 2	Completed	V1.							autops perfor 1 \(\supers	med?	prior to condeath?  1  Yes	mpletion of cause of
VITAII   ysician;	ertifica ector, p	Be C	25. Was case referred to medical examiner?					lace of Dea	ath <i>(Check</i>		2 🔏 1101	1 100	2 3 10
Physi	this c al dire	2	1  Yes 2 No	ospital: 1  lnpatie	T	ER/Outpatient 28b. Time of	3 LI DOA			me 5 K Reside			)
o ugu	ith. : After e funel	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	v, Year)	injury	28c. Inju wor M 1		- 1	8d. Describe ho	w injury occui	red	
DIVISION OF	rector rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At hor	me, farm, stre	et, factory, office		2	28f. Location (St City or Town		ber or Rural	Route Number,
gital C	ours at eral Di filled ir		00 0 110 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1/2					- 1		,		
e Hos	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of e	xamination	and/or investi	gation, in my opin	on, death or	ccurred at t	the time, date an	d place, and d	ue to the cau	use(s) and manner stated.
To th	To the confidence of the confi	~	29b. Signature and fitle of certifier				29c. Licens		and plant		9d. Date sign		
	1,2		755		M			062	1190		8/2	6/2	011
	10th		30. Name and address of person who could SHAHNAWAZ KHAN					LIV C	OITE A	CHOCA	DEAVEN	·=·/ 4	D 3:6:1-
	Stat	e	31. Date Weet (Month, Day, Year)	32. Registr	r's Signati	ure .	I MANY	wy/>	VIICA	LUCIESA	ENIVE	IIY,M	11/2/715
	Registra		SEP 0 8 2011 A	news A.	Asi	arken							

DHMH 17 Rev 7/2009

Albert U. Startt, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28692 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8.3 4 AM 2. Date of Death Physician/ Month auxette Year 7.01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 T Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Min. 1 □ M 2 🔀 F Hours 5/15/1945 145 34 8349 Director NJ 66 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Prince George Oxon HIll 1 🔀 Yes 2 🗌 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2200 Alice Ave. #102 20745 USA 1 and 2 should be filed within 72 hours after death wif Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married þ 1 Yes 2 Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Health Private Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rubin Cannady Eva Mae Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh iment of Health a tant: If item 27 is Natima Wiley/ Daughter 2200 Alice Ave. #102 Oxon HIll, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/25/2011 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crem. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Adenocarcinoma 2009 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last hronic Due to (or as a consequence of) physician Physician/Medical that the death certificate be tenso P.O. Box 68760 the as nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ctopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2 No 9 Unknown Pregnant at time of death Unknown Month Day Year ed by the a signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ addict Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perforn death? **Director;** After this certificate I in by the funeral director, pag 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) re and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) MD 20772 JOHN H. WILLS MD 14310 old Marlboro Pike hopen

DHMH 17 Rev 7/2009

State

Registrar

. Date filed (Month, Day, Year)

AUG 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per med cert G919 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28693 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20<sup>1</sup>1<sup>a</sup>1 Sir Eric Lee Windham 9:00 PM 19 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12112 Bretwood Court Charles Waldorf 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** England 1 X M 2 D F 25 Months Days 7/11371986 **Director** 504 17 4568 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or items 23a Funeral 12112 Bretwood Court 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+ Private Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eric Windham Myrtis Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtis L.Windham/ Mother 12112 Bretwood Ct.Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Trinity Mem. Cem. 8/27/2011 Waldorf, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ligenses 22. Name and Address of Facilit Briscoe-Tonic Funeral Home any 2294 Old Washington Rd.Waldorf,MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ ancel disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burialby Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed 2 No 1 🗌 Yes upleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 - No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) after death. Director: After this 28b. Time of Certificate: 27. Manger of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 - Pending work's 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type) Print) 0 31. Date filed (Month, Day, Year) egistrar's Signature State AUG 2

Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.pt.1.25.pt.11.25.per me. e932 10-12-12 sm State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 22, 2011 ear Mary Ann Woodcock 5:59 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 19 East Poplar Street **Funkstown** Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral 7. Age (In vrs. last birthday) (Month, Day, 1 M 2 X F Days Min Director 62 212-78-3839 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County 1xx Yes 2 No Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 East Poplar Street 21734 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 X Never Married 2 Married Yes 2 No Yes, Give XX 1 ☐ Yes 2X No Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates. White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald A. Woodcock Martha E. Mav 1 and 2 should f Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald A. Woodcock, Sr./Brother 21017 Keadle Road, Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important; If ite Cedar Lawn Mem. Park Aug. 25,2011 Hagerstown, Maryland 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North, Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. **Atherosclerotic Cardiovascular Disease** Interval Between Immediate Cause (Final Onset and Death Physician/ ntellectual disease or condition edur Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical ears 3 Ectopic pregnancy FIGURE (Specify) CERTIFICATION OF STATE OF ST IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown as been signed by the atte Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed Asthma, Degenerative Arthritis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2000 certificate 1 ☐ Yes 2 ☐ No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28b. Time of Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ompleted filled in by determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Decertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier anuth Kate 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kate SMITH 1126 Opal State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month August 28, 20 Ti Harry Richard Williamson, Jr. 8:17M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Allegany Lonaconing 5. Social Security Number 9. Birthplace (State or Foreign Count Pennsylvania If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth Funeral (Month, Day, Year) July 06, 1923 Days Hours 1**X** M 2 □ F 213-12-9093 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at death with the Maryland Director Yes 2 No Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 57 Jackson Street 21539 **USA** items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 72 hours after 1 ☐ Yes 2 No Specify: White 3 Wildowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. narked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Paper 8 Laborer marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Richard Williamson, Sr. Bessie Marie Foutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Shockey - Daughter 19 Robin Street, Lonaconing, Maryland, 21539 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Langust 30, cemetery, crematory or other place, Sunset Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland, Maryland 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumon14 disease or condition Medical resulting in death) Examiner EQ15 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical as t IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ြို 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 021488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Douglas Ave, Long Coning,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

0 8 2011

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VICTOR MONROE WOLFE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign July 8, 1920 1 X M 2 □ F Mary Land Director 220-10-3644 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits notified 28a-f Maryland Frederick Myersville 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code ms 23a oi 10g. Citizen of What Country? Funeral 12442 Wolfsville Road 21773 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ŏ þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 General Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ည Metzer Rertha Gaynel Victor Baughman Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12442 Wolfsville Road, Myersville, MD 21//3 Department of Health an Important: If item 27 is any injury or other trau Mabel Wolfe, spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) German Reformed \$ept.3,2011 Wolfsville, Maryland 21. Signature of Funeral Service Licenses 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh, or heart failure. List only one cause on each line. Interval Between Imm-viate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Lindert, in Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami as the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Dav Year signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? iasete 24a. Was an has performed this certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Accident Suicide 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined

Division of Vital

To the Hospital or Attending Physician:
within 24 hours after death.
To the Funeral Director: After this certific completed filled in by the funeral director,

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

12 Bu

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

State Registrar etters

MO

22911

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Martha Meredith Young 2011 11:30 p<sup>M</sup> August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22680 Cedar Lane Court, Apt. 1217 Leonardtown St. Mary's Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 😿 F Min. Hours **Director** 219-12-2952 88 03/31/1923 Marvland Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No <u>Maryland</u> St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22680 Cedar Lane Court, Apt. 1217 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Black, White, etc. 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker MD State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F marked ည Page 1 and 2 should be Thomas Quirk Meredith Dorothy Drybread other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Bruce A. Young / Son 46898 Glen Mary Farm Road, Park Hall, MD 20667 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episcopal Cemetery 09/03/2011 St. Mary's City, MD Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, Maryland 20650 lichae Jaroli 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition months **Medical** resulting in death) Due to (or as a consequence of): Examiner Alzheimer's 8 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Month Day Year 2 🗌 No g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death. 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactioner, To the best of my knowledge, weath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

31. Date filed (Month, Day, Year)

John S.

Tidball,

who completed cause of death (Item 23a) (Type, Print)

M.D.

D52196

23415 Three Notch Rd., California, MD 20619

August 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amy Arnold	1- For State Registrar	yland / Department <i>Certificate</i>	of Health and Mental F of Death		2011 a. No.	28698		
Physician/ V≏dįcal Examine	Decedent's Name (First, Middle,Last)     Amy Lynn ARnold			Date of Death     Month     August 25,	Day Year	3. Time of Death 0224 hrs		
	4a. Facility Name (if not institution, give street an 4222 Doris Avenue	d number)	4b. City, Town, or Location of Death Brooklyn		4c. County of Death			
Funeral Director	5. Social Security Number 218-96-5896 6. Sex	7. Age (In yrs, last birthday		4 ()				
nd show any ice.	Usual Residence of Decedent  10a. State 10b. County N/A	10c. City, Town or Lo	cation Brooklyn			10d. Inside City Limits 1 X Yes 2 No		
ith the Maryland 23a or 23a-f show notified at once. al Director	10e. Street and Number 4222 Doris Avenue	·	10f. Zip Code 21225	100	g. Citizen of What Cour	utry? USA		
er death w , or items r must be Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced If Yes, Give	ed Forces? es 2 <b>XXN</b> o	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto  Yes 2 No specify:		14. Race - Americ White, etc.	can Indian, Black, White		
5-0036 ed within 72 hours aft tygiene. In Medical Examine Completed by	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) 12 Colleg		dent's Usual Occupation (Give kind of g most of working life. DO NOT use ret Title Researcher		16b. Kind of Business/li Mortgage	ndustry		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Media	James Richard Ar	·	18 Mother's Name Linda	e (First, Middle, Ma Ann Nit	aiden Surname) terright			
MD 21 nd 2 should alth and Me an 27 is ma raumatic cv	19a. Informant's Name/Relationship (Type, Print) Linda Ann Smith /M	other 35	iling Address (Street and Number or E. Barney Street,	Baltimo	re MD 21230	0		
Baltimore, permit. Pages l ar Department of Hea Important: If itee	20a. Method of Disposition  1 Burial 2 Cremation 3 Remov  4 Donation 5 Other Specify:	al from State Argent (	_	31/2011				
	21, Signature of Funeral Service LicenseeViC	>	2. Name and Address of Facility Charles L. Steven 1501 E. Fort Avenu	s Funera e, Balti	l Home, Ind more MD 21:			
Physician Examiner			ne Intoxication	or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death		
ed nsit <b>Examiner</b>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of):	×					
50, te be executed systeian and burial - transit	events resulting in death) Last Due to (or a	as a consequence of):	per me,g919 9-12-	1 1				
3760, fificate be execut g physician and s the burial - tra	IF FEMALE: 23c. If y 23b. Was decedent pregnant in the	es, outcome of pregnancy	Fetal death 3 Ectopic pregna		23d. Date of delivery	ay Year		
D. Box 6876 t the death certificate by the attending phy ached for use as the I Physician/M.	past 12 montns / 4	egnant at time of death 5	Other (Specify)					
S, P.O.  uires that the n signed by d be detach	Part II. Other significant conditions contributin	g to death but not resulting in th	ne underlying cause given in Part I.		acco use contribute to t			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  The Paneral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transilical Certification: To Be Completed by Physician/Medical Elical Certification:				24a. Was an autopsy perform	prior to co ed? death?	opsy findings available ompletion of cause of		
f Vital Physician or this certi	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1	Inpatient 2 ER/Outpati	26.Place of Death (Check onto 3 DOA Other, Nursin		esidence 6 🗸 Other:	Scene		
ion of tending Pleath.  tending Pleath.  tor: After the funeral the funeral ation: T	27. Manner of Death 28a. D	ate of Injury 28b. Time onth, Day, Year) 28b. Time 8-24-11 fd 2:	1 Vas 2 - No	28d. Describe ho Unknown	w injury occurred			
Division o spiral or Attending nours after death. neral Director: After filled in by the func Certification:	3 Suicide 6 X Could not be determined (Spec		treet, factory, office building, etc.	28f. Location (Str or Town, Sta Baltimor	eet and Number or Rur te以222 Doris e.Md.	al Route Number, City S Ave		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the Medical Certificatic	one) 2 Medical Examiner: On the base	sis of examination and/or investi	curred at the time, date and place, and gation, in my opinion, death occurred a					
N N N	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mon August 25, 2011	th, Day, Year)		
)		kaminer 900 W. Baltim	nore Street, Baltimore, MD 21	223				
State	31. Date filed (Month, Day, Year) 32.	Revisitor's Signature	6.01					

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				epartment of Health and Mental Hygiene Sertificate of Death  Reg. N2 0     28699
	Physici Medi		JOHN HNDERSO	2 Date of Death
	Exami	Ш	6000 Arizona Ave.	4b. City, Town, or Location of Death  Baltimore  4c. County of Death  N/A
	Funeral Director		5. Social Security Number  216-34-4214  Usual Residence of Decedent  5. Sex  1	Months Days Hours Min. (Month, Day, Year)
	Maryland 28a-f sho notified at	Director	10a. State         10b. County         10c. City, Town or           MD         N/A         Baltim	Tod. Inside Oily Limits
	h with the ns 23a or nust be r	Funeral D		10f. Zip Code 10g. Citizen of What Country? USA
-0036	within 72 hours after death with the Maryland piene. It than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 X No Specify:  14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036	lled within 72 h I Hygiene. other than "na ent, the Medic	Be Completed	11/11	cedent's Usual Occupation  re kind of work done during most of working  DO NOT use retired)  aborer  16b. Kind of Business/Industry  Beth. Steel
ryland	permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.	To B	17. Father's Name (First, Middle, Last) Thomas Anderson	18. Mother's Name (First, Middle, Maiden Surname) Lucinda Reed
e, Maı	and 2 shortealth and em 27 is not traun	j	Shelia Anderson-Wife 600	illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OO Arizona Ave. Baltimore, MD 21206
Baltimore,	t. Page 1 atment of hardent: If ite		1 Burial 2 X Cremation 3 Removal from State cemetery, c.	position (Name of Pate 20c. Location - City or Town, State Punt Cemt. 9/12/2011 Baltimore, MD
Ba	permii Depar Impor any in		V	22. Name and Address of Facility March F/H 1101 E. North ve. Baltimore, MD 21202
	Ph sician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on earn line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock or ease on earn line.  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Box 68760	death certificate be executed the attending physician and led for use as the burial-transit	/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5	□ Ectopic pregnancy □ 23d. Date of delivery □ Other (specify) ■ Month □ Day Year
P.O.	s that the di gned by the be detached	þ	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Vital Records,	rdificate has been stor, page 2 should	3e Completed	25. Was case referred to medical	24a. Was an autopsy performed 1   Yes 2   No 3   Probably 4   Unknown  24a. Was an autopsy performed 1   Yes 2   No 26. Place of Death (Check only one)
of Vit	er this ce	e: To B	examiner? 1	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
DIVISION		Certificate:	1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be determined   (Month, Day, Year)   injury   28e. Place of Injury - At home, farm, s building, etc. (Specify)	M vork? 1 ☐ Yes 2 ☐ No
J Stimoth	hin 24 hours the Funeral upletely fille	Med	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	occurred at the time, date and place, and due to the cause(s) and manner as stated.  stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  e, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	i O	2	29b. Signature and title of certifier  August 1995  29b. Signature and title of certifier  Management 1995  Management 1995	29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	print) Alub Olen Buxuis 21061
	State Registra		31. Date filed (Month, Day, Year). 32 Sesistrar's Signature SEP 0 9 2011	arles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Rouney Adkins		State of Ma 1- For State Registrar		rtment of tificate of	Health and Me Death	ental Hygiene	Reg. No	2011	28700
Physic Medical Exam	ian/ iner	Decedent's Name (First, Middle,Last)     Rodney E. Adkins				2. Date of Month		Year	3. Time of Death 1330 hrs
1		4a. Facility Name (if not institution, give street ar	nd number)	41	. City, Town, or Location		4	c. County of Death	
Funera		Baltimore Washington Medical Co  5. Social Security Number 6. Sex	7. Age (In yrs. la:	st birthday)	Glen Burnie	nder 24Hrs. 8. Date		Anne Arundel	
Directo		216-86-6548 1XM 2		49 Yrs.	Months Days Ho	urs Min.	. 29,	Foreig	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Locatio	1		10d. Inside City Limits		
Maryland 28a-f show d at once,	ō	Maryland Anne Arund	lel		asadena				1 Yes 2 No
e Mary nr 28a-	Director	10e. Street and Number 756 213th Street			10f. Zip Code		10g. Ci	tizen of What Coul	
with th ns 23a	Jal	11. Marital Status 12. Was	Decedent Ever in U.S		21122 Decedent of Hispanic C				ican Indian, Black,
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Headin and Mental Hygene.  "matter all", if item 27 is marked other than "natural", or items 23a nr 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Y	ed Forces?		, specify Cuban, Mexic		:.)	White, etc.	
ours after trural"	d by	3 Widowed 4 Divorced If Yes, Giv. or Dates:  15. Decedent's Education (Specify only highest		16a. Decedent's	es 2 No speci Usual Occupation (Given	ve kind of work done	16b.	Specify: Whi	
16 n 72 ho ian "na ical Ex	Completed	Elementary/Secondary (0-12) College	ge (1-4 or 5+)	during mos	t of working life. DO NO	OT use retired)			
-003 d withi giene. ther the	E O	10 17. Father's Name (First, Middle, Last)		Cons	truction	ner's Name (First, Mic	ddle. Maider	Residen	tial
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	Rodney Adkins				• '	lowma	•	
MD 2' nd 2 should afth and Mo on 27 is ma	မ	19a. Informant's Name/Relationship (Type, Print			ddress (Street and N				, Zip Code)
re, MD 2 I and 2 shoul Health and M Fitem 27 is m		Lenora Loughry - Mothe	20b. Pl	lace of Disposition	13th Stree on (Name of cemetery,	t, Pasader Date	1a, ML 20c.	21122 Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Impartant: If ites		1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other Specify:		ematory or othe n Haven	Cemetery	Sept. 1	0 (	Glen Burn	nie, MD
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 277 injury ar other traum.		21. Signature of Funeral Service Ucensee	11	)	ne and Address of Faci			neral Ho	
Physician		23á. Part I. Enter the disease, or complications the	at saused the death. I	311 Do not enter the	1 Mountain mode of dying, such as	Rd., Pasa cardiac or respirato	adena, ry arrest, sh	, MD 2112 lock, or heart	2 Approximate Interval
/Medical £xaminer			ary Artery	compli	ovascular l cated by co	Disease an Ocaine use	d Tun	nel	Between Onset and Death
		b and the same of	as a consequence of):	:					
	iner	cause. Enter Underlying Cause	as a consequence of):						
sit sa	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or	as a consequence of):	:					
(68760, certificate be executed anding physician and use as the burial - transit	lical	d.  X UNPENDED AMENDI  IF FEMALE: 23c. If y	D23a,pt.II	7,27,per	me,g919 9	-13-11 sm			
760, ficate be g physic the bur	/Mec	22h Mos desedent programmt in the	es, outcome of pregna		• □ = ·		23	3d. Date of delivery	
Box 6876 death certificat the attending phyde for use as the	Physician/	past 12 months?	ve birth regnant at time of deat	, - <del>-</del>	death 3Ector	pic pregnancy		Month D	ay Year
D. Bo; t the deat by the att	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contribution	nknown	ulting in the unc	erlying cause given in	Part I 23e	Did tobacco	use contribute to	the cause of death?
P,( es tha gned se det	d by	Methadone Use					_		ably 4 🗹 Unknown
of Vital Records, sg. Physician: The law require. the this certificate has been si neral director, page 2 should be	Completed by						Was an autopsy	prior to o	topsy findings available ompletion of cause of
tal Rec	S					1 🗸	performed? Yes 2 N	death? 1 ✓ Ye	s 2 No
Vital ysician: his certi director	o Be	25. Was case referred to medical examiner?	Inpatient 2 🗸 E	R/Outpatient 3	Louis -	h (Check only one)  Nursing Home	Reside	ence 6 Other	
of \ng Phy	-1			28b. Time of Inju				ury occurred	
Division tal or Attendi rs after death. at Director: A	catio	Natural 5 Pending 2 Accident Investigation			1 Yes 2				10 1 11 1 2 2
Divi	Certification	3 Suicide 6 Could not be determined (Spec		ne, farm, street, t	actory, office building,		wn, State)	and Number of Rui	ral Route Number, City
Division  To the Hospital or After within 24 hours after dea Tra the Funeral Director completely filled in by the		29a. Certifier 1 Certifying Physician: To the							
To th withir Ta th compl	Medical	one) 2 Medical Examiner: On the ba and mann 29b. Signature and title of certifier		Vor investigation	, in my opinion, death of			Date signed (Mon	
		Carol Has	lan		O.C.M.E.			otember 7, 20	
Ø		30. Name and address of person who completed of							
2	ate		al Examiner 90 Registrar's Signature		ore Street, Baltim	nore, MD 21223			
Regis	rar	SEP 0 9 2011	A. box						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		artment of H		d Mental Hy	/giene Reg. 20	11 2	28701
	Physicia		1. Decedent's Name (First, Middle, La	BUTLEY				2. Date of Do Month	eath Day	Year -2011	3. Time of Death
-	Medi Examir		4a. Facility Name (if not institution, giv	e street and number) 5009 Frank I VURSING F	ind Ave	4b. City, Town, or Ba\カネ	nore	eath CTY	4c. Count		
	Funeral Director		5. Social Security Number 6. :	Sex 1 □ M 2 🔀 F	yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Ars. 8. Date of Bi	rth		ice (State or Foreign
	Maryland 28a-f show otified at	Director	10a. State 10b. County  MD N/A	100	d. Inside City Limits						
	s 23a or 3	<u></u>	10e. Street and Number 3569 Elmora Ave	What Countr	y?						
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show motochart: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Sec. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W Specify: 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Yes) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Yes) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Yes) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)									
Baltimore, Maryland 21215-0036	d within 72 ho ygiene. <b>her than "na</b> <b>rt, the Medic</b>	e Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 12th	usiness Indu	stry Balto. System						
yland	should be filed and Mental H is marked of raumatic even	To Be	17. Father's Name (First, Middle, Last)	OTTAWIT				Name (First, Middle ie John:		e)	
e, Mar	and 2 shou Health and em 27 is n ther traum		19a. Informant's Name/Relationship ( Tara Robinson-I	aughter	3569	Elmora		Rural Route Number Baltimo:			
timor	it. Page 1 artment of hartment of hartment: If its		20a. Method of Disposition  1 🕱 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Spec	Removal from State		atory or other place. .lls Mem		13/2011		eRive	c, MD
Ba	Depar Impo any ir		21. Signature of uperal Stryice Licer		Av	e. Balt	imore	March F , MD 21	202	E. I	North
F	hysician/ Medical	i N	23a. Part 1. Enter the disease, or com shock, or heart failure. List only a Immediate Cause (Final disease or condition resulting in death)	polications that caused the one cause on each line.  Se ps   Due to (or as a con	518	r the mode of dying	i, such as card	liac or respiratory a	rrest,	li C	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. ANO 7 Due to (or as a con	KIC B	RAIN	1NJ	URY			21 months
8	ite be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. STA	sequence of):	STHM	ATIC	22			LI month
3760	g physicia sthe buri	Aedical		ld. A 57	HMA	<del>}</del>					63 yrs
. Box 68	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【KNo 9 ☐ Unknown	23c. If yes, outcome of pre  1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3 🔲	Ectopic pregnancy Other (specify)	′			ate of delivery onth Da	
ls, P.O	requires that the desibeen signed by the a should be detached	by	Part II. Other significant conditions of	ontributing to death but no	t resulting in the un	derlying cause give	en in Part I.		obacco use cont Yes 2 □ No		cause of death?
Division of Vital Records, P.O. Box 687	sician: The law req certificate has bee irector, page 2 shoi	Completed	SEIZURE	DISOADER		1L43		24a. Was – auto perfo 1 □ Yes	psy ormed?	Were autopsy prior to comp death? 1 \(\sum \) Yes 2	y findings available bletion of cause of
† Vital	rnysician this certif al directo	: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death		ER/Outpatient	3 DOA Other	4 Nursin	heck only one)	*		
VISION 0	our nospiration of Autenting Proysicans, within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be determined		at home, farm, stree				Now injury occurrence of the state of the st		oute Number,
בֿ	in 24 hours a he Funeral D	Medical C	(Check 2 L Medical Exam	sician: To the best of my kr iner: On the basis of examin- se Practioner: To the best of	ation and/or investic	ation, in my opinion	<ul> <li>death occurre</li> </ul>	e, and due to the ca	use(s) and mann	e to the cause	e(s) and manner stated.
			29b. Signature and title of certifier	dusein	~ MD	29c. License	number	532	29d. Date signed	d (Month, Day	v, Year)
	8			completed cause of death (I		,					ON MD 212
	Stat Registra	C .	31. Date filed (Mooth, Day, Year)  SEP 0 9 20	32 Registrar's Sig	gnature S. Jack						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28702 State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ ACK GILIE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 80m oun Gene olumbis Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Virginia 1**X** X M 2 □ F Months Days Hours Min 02-06-1932 **Director** 248-42-7316 79 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No E1kridge MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6250 Old Washington Road 21075 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: White 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Law Enforcement Police Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mabel Olive Becude Robert Atkins Burk and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tran 6250 Old Washington Rd., Elkridge, MD 21075 Mary E. Burke - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Park | 09-08-2011 4 Donation 5 Other (Specify) Elkridge, Maryland 21. Signature of Funer of ervice Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at a Inc, 7250 Washington Blvd, Elkridge, MD 21075 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ a disease or condition resulting in death) Medical Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes ∠ L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **^** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has ! autopsy After this certificate 25. Was case referred to medical examiner?

1 \sum Yes 2 \sum No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina 2 🗌 No Accident Investigation 24 hours after deal Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my included a set of course at the time case and does not consider the requested and manner stated (Check within 2 only one the 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 1)30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Rive Neck Abad ballonie

Registrar PHMH 17 Rev 7/2009

State

201-10

Jabapalhi

31. Date filed (Month, Day, Year)

9 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State of Mar		Certificate of t		, ,	Reg. NO 1	1 28703
	Physicia	an/	1. Decedent's Name (First, Middle, Las	,				2. Date of Dea	th	3. Time of Death
	Medi	cal	Stanley C.  4a. Facility Name (if not institution, give		ski	4h City Town o	v Location of Death	Septem	ew 7, 21	
	Examir	ner	Baltimore Washing	· · · · · · · · · · · · · · · · · · ·	L Cente		r Location of Death n Burnie		4c. County of D	Peath : Arundel
1	Funeral	Г	5. Social Security Number 6. S		n yrs. last birth	day) If Under 1 Year		8. Date of Birth	g.	Birthplace (State or Foreign Country)
	Director	ı	214-20-9749 Usual Residence of Decedent	LAY IVI Z L F	85	rs.	Tiodio Willia	(Month, Day, May 7,	1926	Maryland
	and show dat	ē	10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
>	Maryl 28a-f otifie	irec	Maryland Anne A	rundel	Pa	sadena				1 ☐ Yes 2 🔀 No
3	th the 3a or t be n	a D	10e. Street and Number 7903 Whites	Corro Dood		10f. Zip Code	21122		10g. Citizen of Wha	
Z Z	ems 2	Funeral Director	11. Marital Status	Cove Road  12. Was Decedent Ever	in U.S.	13. Was Decedent of H		ecify Yes or No-		USA American Indian,
_1	ter de , or it		1 Never Married 2 Married	Armed Forces?  1 A Yes 2 No		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		Rican, etc.)	Black, V	Vhite, etc.
17 or	ours af	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates. 19					Specify:	White
, _ T	72 hc an "na Medio	mple	15. Decedent's E (Specify only highest gra	ade completed)		Decedent's Usual Occup (Give kind of work done of life, DO NOT use retired)	during most of work	ing	16b. Kind of Busine	ess Industry
7 6	withir giene er the		Elementary/Seconday (0-12)	College (1-4 or 5+)		Firefight			Balti	more City
a ( emsk i	e filed ntal H) ed oth	To Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
9 3	ould bod Mer mark matic		Frank Balews Frank		10h	Mailing Address (Street	Palagia		walski	7'- 0-1-1
	d 2 sh alth ar 27 is er trau		Gertrude J. Balev							yland 21122
(3 Baltimore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Hygiene.  D		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter	Disposition (Name of , crematory or other place	ce)	Date	20c. Location - City	or Town, State
<u> </u>	it. Pag rtment rtant: njury o		4 Donation 5 Other (Specif	5)	Cedar I	Hill Cemete		12	Brooklyn	, Maryland
8 8	permit Depar Impor any in		21. Signature of Funeral Servic 1 Liums	2		22. Name and Addres	3		Funeral a, MD 211	
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only o	plications that caused the ne cause on each line.	e death. Do no					Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	nmo					Onset and Death
-	Examiner			Due to (or as a co	nsequence of		next i	a		
	ait d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nisequance o	i,-				
	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence o	n):	-			
092	te be e nysicia ne bur	Physician/Medical		d						
687	ertifica ding pl	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy					
Вох	eath certifice attending p	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at tim	Fetal death	3  Ectopic pregnand 5  Other (specify)	у		23d. Date of Month	delivery Day Year
	t the d by the tachec	Phys	9 Unknown	9 Unknown						
0.9	requires that the de been signed by the should be detached	[출	Part II. Other significant conditions of	ontributing to death but n	ot resulting in	the underlying cause give	ven in Part I.			e to the cause of de?
rds	requir been s	letec						24a. Was ar		autopsy findings available
ecc	The law cate has page 2	Completed			· · · · · · · · · · · · · · · · · · ·			autops	by prior	to completion of cause of
<u> </u>	ician: The certificate rector, pag		25. Was case referred to medical examiner?			26. PI	ace of Death (Chec		2 LT No. 1 L	Yes 2 No
Ş	Physic this ce al dire	မ	1 ☐ Yes 2 1 No			patient 3 DOA Othe	4 ☐ Nursing Ho	me 5 Reside	nce 6 Other (S	oecify)
o uo	nding Physician: Tath. r. After this certifics e funeral director, p	icate	27. Manper of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Ye	ear) 28b. Ti	ury work		28d. Describe ho	w injury occurred	
Division of Vital Becords.	e Hospital or Attendin 24 hours after death. Funeral Director: Aft leted filled in by the fur	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp		n, street, factory, office		28f. Location (Str City or Town		Rural Route Number,
۵	Hospital 24 hours a Funeral L	Medical (	29a. Certifier 1 Certifying Phys	sician: To the best of my l	knowledge, d	eath occured at the time	, date and place, ar	d due to the caus	se(s) and manner as	stated.
20.	To the Hos within 24 h To the Fun completed	Med	(Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of exami se Practioner: To the best	ination and/or	investigation, in my opinio	on, death occurred a	the time, date and	d place, and due to t	he cause(s) and manner stated.
V.	To vit		29b. Signature and title of certifier	& Wich	西	7, D. 29c. License	9 number 41365	2	9d. Date signed (Mo	er 7, 2011
	4+		30. Name and address of person who c	completed cause of death	(Item 23a) (T	(pe, Print) 301	Ausp	fat 1	vine -	10171
(6)	-1		Jeovae C, V 31. Date filed (Month, Day, Year)		[] []	),	Hen B	uvnie	MD, 2	0161
_	Stat Registra		SFP 0 9 20	32/Registrar's S	agnatue	parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BEGUM. 1 AMIDA 2011 Medical O 4a. Facility Name (if not institution, give street and number, Town, or Location of Death **Examiner** 4c. County of Death Washington Baltimore Medicas Social Security Number Link 6. Sex If Under 1 Year If Under Funeral 8. Date of Birth 9. Birthplace Months Min. Days Hours (Month, Day, **Director** Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗙 No OTTON 10e. Street and Number 10f. Zip Code Citizen of What Country? Funeral 28 OUE! 101 0 IRP stan 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DQ NDT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name First, Middle, Maiden Surname ျှ non 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grandson Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) -2011 Signature of Funeral Service Licence any Willie 000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician Medical HEART ONGESTIVE disease or condition resulting in death) Due to (or as a consequence of) Examiner MAEMIC 22 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed 73 Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical DERICHLAEMIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year a. No signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown page 2 should 1 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed death? 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5  $\square$  Pending hours after death uneral Director; A 1 🗌 Yes 2 🗌 No ☐ Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Du052205 PRATIGHA SHARMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE 21225 300 SOUTH HANDUER MD -31. Date filed (Month Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year a 30 Physician/ CHARLES C. BROCATO Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner HARFORD JOPPA 1614 STOCKTON ROAD 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5 Social Security Number LOUISIANA **Funeral** Months 1 💢 M 2 🗆 F 02/19/1916 219-09-3623 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f shov event, the Medical Examiner must be notified at Funeral Director 1 Tyes 2 X No JOPPA HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA items 23a 1614 STOCKTON ROAD 21085 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Specify: WHITE 1 Never Married 2 Married ò þ 1 ☐ Yes 2 👿 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3 X Widowed 4 Divorced Year or Dates. "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) SHOE REPAIR SHOP and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) SELF EMPLOYED 4 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or att DORA BROCATO မ FILIPO BROCATO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1614 STOCKTON ROAD JOPPA, MD 21085 BROCATO- SON FRANK C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 9/10/2011 HOLY REDEEMER CEM. MILLER-DIPPEL FUNERAL HOME 22. Name and Address of Facility 21. Sanature of Funeral Service Licensee 6415 BELAIR ROAD BALTIMORE, MD 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e 051 Immediate Cause (Final prosta (fatic Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) 23b. Was decedent pregnant Live Birth 2 Fetal death Month Year in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Tes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 1 ☐ Yes 2 ☐ No Yes 2 X No 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 2 **Z** No 1 Yes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature an MD

State

Registrar

saltimore, MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ezst

9

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day EPTEMBER 9:47 AM Edward Jerry Beach 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hasip ALTIMORE Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Hours 212-46-7843 64 M##Tr4ay, 18947 Marwland Director Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Eastwood 1 Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21224 7315 Bridgewood Drive 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛣 No Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Beach Mary Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7315 Bridgewood Drive Baltimore, Md. Dorothy Gollahon/ sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 7,2011 Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, Dundalk Avenue Baltimore, Md. 21222 1201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Ph sician/ disease or condition HOUR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month Year Yes 2 No 9 Unknown a | Linknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of nas autopsy page performe death? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Tes Other: ျ 1 Inpatient 2 ER/Outpatient 3 I DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion and an advantage of examination and/or investigation, in my opinion and an advantage of examination and or investigation, in my opinion and at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS 5 CHARLES 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

ORIGINAL

SEP 0.9 2011

Registrar

Please Type or Printin Black Indelibled, Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1319 Clarkson Street N/A Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 214-56-8110 Director 62 1 □ M 2 🗶 01-20-1949 Pennsylvania 28a-f show 10b. County Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland N/A Baltimore City ō 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 1319 Clarkson Street 21230 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or ģ 1 Never Married 2 Married Yes Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Kochel Antoinette Cotolese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Houston Creighton - SON 1319 Clarkson Street, Baltimore, MD 21230 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 5 Other (Specify) Crematory INC 108-31-2011 Baltimore Maryland 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road, Baltimore MD 21228 21. Sit 23a. Part 1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death 2 No 9 Unknown g | Hnknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 Unknown 1 Yes 2 No Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA TNursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After t 1 Natural 5 Pending 1 Yes 2 No Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) State SEP 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Thornie Causey 1.20 A M 8 2011 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death IOW SON TIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year) April 28, 1929 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 042-30-9431 Months 1**X** M 2 □ F Director South Carolina 82 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8703 Richmond Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Loyola College Physical Plant Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Dawson Causey Jet Gore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 8703 Richmond Avenue-Parkville, Maryland Marjorie Causey-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery Sept.12,2011 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacilly, Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a cons duence of) Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ္ 1 Tes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) D61731 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) SEP 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kenneth George Caldwell, Sr. ,2011 Year Month September 11:26P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 0akcrest Balto. Parkville Social Security Number 8. Date of Birth (Month, Day, Year) May 7,1921 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Hours Mary land Director Yrs 215-12-9955 90 May Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified Md. Balto. Parkville 1 Tes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 8820 Walther Blvd.4408 Chesapeake Ct. 21234 USA items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner was becedent Ever in 0.5.

Armed Forces?

1 X Yes 2 □ No

If Yes, Give

Year or Dates. 1942 - 1945 Black, White, etc ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural". Completed 3 Widowed 4 Divorced Specify. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) other 4 Marketing Director Telephone Company Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ William T. Caldwell Henrietta Thiess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry T. Caldwell Son 380 Shores Way Boone, NC. 28607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Garrison Forest 9-13-2011 Owings Mills, Md. Signature of Funeral Service Licens 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ erebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): nding physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten in the past 12 months? Year signed by the at d be detached for Pregnant at time of death Yes 2 No g Unknown g 🗌 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperknsive Cardiovascular Disease Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death. has page 2 autopsy certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Hospital 1 Tyes Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signatur

Michealle

Date filed (Month, Day, Year,

SEP 0 9 2011

G. H

amson 8800 Walther Blvd, Parkville, MO 21234

Chel, MISN cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year) 2011

Please Type or Print in Black Indelibled hk. Ensure All Copies Are Legible. 287 10 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David son 21028 1/0 stember 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins the spital Limone N/A Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Hours Min. (Month, Day, Yea Colorado **Director** 216-64-2789 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No VA Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1792 Duffield Lane **USA** 22307 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Intelligence Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Francis Davidson Claire Ellen Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1792 Duffield Lane Alexandria, VA Joseph M. DeThomas, husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 09/02/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Lung adenocarcin Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 🗡 No Other: မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Katural work? 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number RES-000

Registrar

DHMH 17 Rev 7/2009

State

600 North Wolfest Baltimore. Mde 21287

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOWER EDWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Center Randallstown Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year, 218-44-9040 Director 1 XM 2 □ F 62 May 11, 1949 Alabama Usual Residence of Decedent 28a-f show 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No <u>Maryland</u> Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4508 Springdale Avenue 21207 Was Deced Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify **Black** 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Scaffolding Construction 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leon Dower Mary Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Barbara Dower, Wife 4100 The Alameda Baltimore. item 2 Marvland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. ō 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc. 09/08/11 Metro Baltimore, Maryland Signature of Funeral Service Licenses Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 739 Frederick Road Baltimore, Mary Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ANCEK Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ò in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 1 Yes 2 L 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 🖎 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Yes hin 24 hours after death.

the Funeral Director: After this certifics
mpletely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. o the Hu within 2/ To th/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934

DHMH 17 Rev 06-2011

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September<sup>Day</sup>2, 2011 Physician/ Elizabeth Mary Dunwiddie 8:00 PM Medical 4a. Facilify Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Columbia Howard 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days 488-32-4777 Director 1 □ M 2 🕇 F 80 Oct 4, 1930 Missouri 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane 21044 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 **X** No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) National Security Elementary/Secondary (0-12) College (1-4 or 5+) 12 Executive Secretary Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ျ Bruce Rambo Dunwiddie Ruth Lighton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Michael Dunwiddie/nephew 10600 Spotted Horse Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Final Journey Crematory 09/09/11 Woodbine, MD 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Heckrotte, P.A. MO1251Beverly L Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery ξ in the past 12 months?

1 Yes 2 X No Month Dav Year detached 9 Unknown 9 Unknown · by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 XNo 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: assisted မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Spe Certificate; 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Fune completely fi 29a. Certifier

State Registrar 29b. Signature and title of certifier

30. Name and address of perso

Andrew Lazris

31. Date filed (Month, Day,

6334 Cedar Lane Columbia, MD 21044

par

who complete gause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D47447

29c. License number

29d. Date signed (Month, Day, Year)

September 8, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 1, 20<sup>'</sup>1 11:00 Desira D. DeWitt Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2007 Klein Plaza Drive Forest Hill Harford County Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 5, 1944 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2X🗆 F Hours Min. Virginia Director 215-42-0604 67 Usual Residence of Decedent 10a, State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2X No Maryland Harford County Bel Air ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 725 Fox Bow Drive 21014 United States 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. "natural", or ite Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ed other tevent, the 12 Liquor Distributor Accounting CPTEMBER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ည James M. DeWitt Katie Reynolds traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Healt Important: If item 2 any injury or other <u>Dwight D. DeWitt/Brother</u> Fox Bow Drive Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 9/4/11 Glen Burnie, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Road Bel Air, Maryland 21014 Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading is immediate Due to Jor as a nonsequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Li retail 2000
Pregnant at time of death Day Year the 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an 24b. has 2 🗌 No Yes 1 Yes 25. Was case referred to medica To Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide hours after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 2300 Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

This is not the contract of th

State

Registrar

31. Date filed (Month, Day, Year,

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ()9 ENRIQUEZ 0629AM Guillermo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD HAVre de GRACE HARFORD MemoriaL HOSDITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 **X** M 2 □ F Days Hours None Argentina 59 Director May Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Aberdeen 1 X Yes 2 ☐ No Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 N. Rogers St, Apt. A 21001 Argentina 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Argentina Specify: Hispanic Completed 3 Widowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Taxi Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guillermo Enriquez Maria Ares 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marta Rivero Wife 18 N. Rogers St, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A. Ferris & Co. 20c. Location - City or Town, State West Chester, Date 1 Burial 2 X Cremation 3 Removal from State 19/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signatury of Fund Tarring-Cargo Funeral Home, 333 S. Parke St, Aberdeen, N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Acute CORONARY Pnysician/ disease or condition resulting in death) Medical **Examiner** SC/EROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OMAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2**X** No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of ce 29b. 29d. Date signed (Month, Day, Year) DOO 69864 PHYSICIAN n who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Timothy B.
31. Date filed (Month, Day, Year)

400	Type of I fille in Di	dok machbie mk	Ellouio Ali Gopio	J AIC L
	State of Maryland	/ Department of He	alth and Mental Hy	glene

		For State Registrar	State of Ma	aryland		artment of tificate of	Health and Death	Mental H	ygiene Reg. Na		
		1. Decedent's Name (First, Middle,				outo or		2. Date of D		2011	2Til of Death 6
Physicia /Medica		THOMAS D.				4 6 7		SEPTEM	BER	6 2011	05:54 M
Examine	er	4a. Facility Name (If not institution, substitution)		enter		Baltimore	or Location of Deat	п	40	. County of Death	1
Funeral Director		5. Social Security Number 220-24-6900 6. Sex 1XXM 2 $\square$ F 81 Yrs. 81 F 0. Age (In yrs. last birthday) 81 Yrs. 1 F 0. By 1 F 0.									nplace (State or Foreign ntry) ryland
yland how at		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation		······			10d. Inside City Limits
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Director		imore		Dun	dalk			1 10 0		1 X Yes 2 □ No
3a or		10e. Street and Number 2507 Ambler Co	nurt			10f. Zip-Code 212	222		10g. Cr	tizen of What Cou	,
ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?			1	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Amer Black, White Specify: W	
natural Ical Ex	sted	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occu	ipation during most of wo	rkina	16b. l	Kind of Business/	Industry
than "i	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Rad	io NOT use retire	nnician	9	Ba1	timore	County
n and Mental Hygiene. Is marked other than raumatic event, the M	To Be Co	17. Father's Name (First, Middle, La Clement Lai	·				18. Mother's Na Mary	<sub>me (First, Midd</sub> Jane 1			
12 S		19a. Informant's Name/Relationshi Brian W. Evan		:	l	•	et and Number or R		Air	, Md.	21014
Department of Hes Important: If Item any Injury or othe onca.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Special Service License)		Ce	metery, cren yview	sition (Name of natory or other place of the Crema)  Name and Addi	tory 8	otembe 2011 zorow	Ba1		rown, State , Maryland 1 Home, PA
를 다 하이		From front	~		1	201 Dui	ndalk Av	enue [	Balt		Md.21222
rsician		23a. Part 1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition	omplications that caused ly one cause on each line aSEPSU	е.	Do not ente	er the mode of dy	ring, such as cardia	ic or respiratory	arrest,		Approximate Interval Between Onset and Death
Medical caminer		resulting in death)	Due to (or as a			POWEL					
± .	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as a								
	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a conseque	ence of):						
as the	Medical		d								
ed by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 🗌 Fetal	death 3	Ectopic pregnar Other (specify)	су		-	23d. Date of deli Month	very Day Year
pe q	þ	Part II. Other significant condition	s contributing to death b	ut not resu	Iting in the u	nderlying cause	given in Part I.				the cause of death?
page 2	Completed							24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
certificate lirector, pag	Be	25. Was case referred to medical examiner?	Hospital:			01	26. Place of Dea				
er this derail di	임	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur	у	R/Outpatient 28b. Time of	28c. Inji	ury at	28d. Describ		6 Other (Spec ary occurred	ity)
the fun	catio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no			Injury	M 1	xrḱ? ]Yes 2 ∏ No	20f Location	(Stroot o	and Number or Pi	ent Pouto Number
	Certification:	4 Homicide determin		. (Specify)				City or To	own, State	e)	ural Route Number,
24 ho e Fune letely f	Medical		caminer: On the basis of and manner sta	examination							
within To the comp	Me	29b. Signature and title of certifier					se number		į.	ate signed (Month	
		30. Name and address of person w	THA GANJ	1		Print)	4940	Eastern A	venu	e, Baltimo	ore, MD, 2122
State Registra	~	31. Date filed (Month, Day, Year)	32. Registral		_						
HMH 17 Rev 1/200		SEP 0 9 201	1 Januar	J.	May						

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Finley 8:16 AM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth nth, Day, 1 **X** M 2 □ F Months Hours Min 88 Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Baltimore 1 Yes 2 No 10f Zin Code 10g. Citizen of What Country? 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 15 Decedent's Education 16b. Kind of Business Industry Balto. 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working County Dept. of life. DO NOT use retired) Elementary/Seconday (0-12) ngineer Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Finley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balton, MD 2703 Westwood Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of XBurial 2 ☐ Cremation 3 ☐ Removal from State 9-8-2011 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solice Licens 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Demen river Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should After this certificate has been 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy Yes 2 ♣N 1 Yes 2 KNo **Division of Vital** director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 2 🗷 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 → > () C = funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural work? 5 Pending injury 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) fagges D 000 2290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ille 465 21201 31. Date filed (Month, Day, Year) State Registrar

Joe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SHIRLEY A. FEATHERS September 4,2011 12:53 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rosedale Franklin Cente Baltimore Hospital **Funeral** 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 X F Months Davs Hours 40777774936 **Director** TENNESSEE 219-26-7243 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 28a-1 MD BALTIMORE 1 Yes 2 No **ESSEX** 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be 23a 1000 FRANKLIN AVENUE 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced If Yes, Give Specify: Completed WHITE Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12)
11TH GRADE College (1-4 or 5+) BOTTLE INSPECTOR SODA CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WILLIAM C. HUBBARD DOLLIE BLUE and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 FREDERICK FEATHERS/SON PERRY HALL, 11 MALLOW COURT MDor other 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o METRO CREMATORY, INC. 9/6/2011 CATONSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lio, n MO1,139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. di 8521 LOCH RAVEN BLVD. TOWSON, MD 23a/Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Bronchogenic Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Year Pregnant at time of death signed by the a d be detached f the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Yes Other: 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident 1 🗌 Yes Investigation Funeral Director: A sted filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address rson who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	naryland / Der Ce	oartment of F ertificate of L		Mental Hy	/giene 0	28719									
	Physicia		1. Decedent's Name (First, Middle Marian	L.	Foresman			2. Date of Do		3. Time of Death 4:50 PM									
And the second	Medi Examii		4a. Facility Name (if not institution Genesis Healtho		ds Lane	4b. City, Town, or Brookly	r Location of Dea		4c. County of D	eath									
	Funeral Director		5. Social Security Number 190-22-2512 Usual Residence of Decedent	6. Sex 7. A <sub>ξ</sub>	ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	Birthplace (State or Foreign Country) Ohio									
	Maryland 28a-f shor otified at	Funeral Director	MD 10b. County Anne	Arundel	10c. City, Town or L	ocation	Severna	Park		10d. Inside City Limits 1 ☐ Yes 2 ※ No									
	with the s 23a or s ust be n	eral D	10e. Street and Number 135 Wild Oak R	oad		10f. Zip Code	21146		10g. Citizen of What United	Country?  States									
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 <b>X.Y</b> Widowed 4 ☐ Divorced			Was Decedent of Hi If Yes, specify Cuba 1 Yes 2xx No	ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wi	merican Indian, hite, etc. Thite									
Maryland 21215-0036	within 72 hor giene. ner than "nat t, the Medica	• Completed by		nt's Education st grade completed) College (1-4 or	(Give	edent's Usual Occup e kind of work done d DO NOT use retired) Telemark	during most of wo	orking	16b. Kind of Busines	·									
yland	ild be filed Mental Hy rarked oth	To Be	17. Father's Name (First, Middle, L Paul Alison Le	,				<sub>ume (First, Middle,</sub> eta Wise	Maiden Surname)										
, Mar	nd 2 shou lealth and m 27 is m	l	19a. Informant's Name/Relationsh Becky Batta -						er, City or Town, State, . rk, Maryla										
Baltimore,	Page 1 a ment of H tant: If ite iury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State pecify)		matory or other place	· •	Date 08-2011	20c. Location - City Elkridge,										
Ball	Departing Departing Important Information and Information Conce.		21. Signature F neral Service L	3. Isroh	Zun 2	2. Name and Addres	ss of Facility Ga:	ry L. Ka sh. Blvd	ufman Fune ., Elkridg	ral Home at e, MD 21075									
aria F	Physician/ Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. a.	е.	ter the mode of dying		c or respiratory ar	rest,	Approximate Interval Between Onset and Death									
	Examiner and II-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Lue to (or as a	a consequence of):														
260	cate be executed physician and s the burial-transit	edical I		d															
. Box 687	ne death certificate be executed y the attending physician and iched for use as the burial-transi		ysician/M	ysician/M	ıysician/M	ysician/M	nysician/M	ysician/M	nysician/M	ysician/M	ıysician/Me	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	4		23d. Date of d Month	delivery Day Year
ds, P.O.	requires that the dec been signed by the a should be detached		Part II. Other significant condition  De Menti		ut not resulting in the u	underlying cause give	en in Part I.		obacco use contribute of	to the cause of death?									
Vital Records,	icate has be r, page 2 sh	Completed by						24a. Was a autop perfo	prior to rmed? prior to death?	utopsy findings available completion of cause of									
/ita	ysician: is certific director,	m	25. Was case referred to medical examiner?  1 ☐ Yes 2 XNo	Hospital:		Othor	ce of Death (Chec		(										
on of \	ath. :: After this e funeral c	icate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date of injur (Month, Day	ent 2 ER/Outpatier y 28b. Time of injury	28c. Injury work?	4 L Nursing H at		lence 6 Other (Spe	ecify)									
Division of	within 24 hours after death.  To the Funeral Director. After thi completely filled in by the funeral	al Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be	ry - At home, farm, str . (Specify)			28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of part II.   1   1   1   1   1   1   1   1   1																			
٩	wit Cor		29b. Signature and title of certifier	niem M.	1)	29c. License 1	number		29d. Date signed (Moni										
			30. Name and address of person wh	IEN1, 20.	2 W. M	APLE R		VTHICU	1H, MD 2	1090.									
	State Registra	_	31. Date filed (Moħth, Day, Year) SEP 0 9 20	32. Registrar	r's Signature	المما			-										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 6, 2011 **Physician** Frederick 5:00 p м aroline /Medical . County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care- Rossville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 13, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🖼 F 89 216 16 1796 Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner mentice event, 1 ☐Yes 2 ☐No Baltimore MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 1816 Sunnyside Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Exercises 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Specify: ⋛ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Circuit Court Baltimore Co. Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Katherine Montgomery Andrew Schmidt ပ 19b. Mailing Address *(Street and Number or Ryral Route Number, City or Town, State, Zip Code)* 518 Spring Lane Baltimore, Maryland 21221 19a. Informant's Name/Relationship (Type. Print) 518 Spring Lane Donald Frederick 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕮 remation 3 ☐ Removal from State Baltimore, Maryland 9/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22 Nanssahn Funeral Home, Inc. 7401 Belair Road Baltimore, MD Inc. 21. Signature of Fundamer Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** den /Medical Due to (or as a consequence of): Examiner FT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No within 24 hours after death. To the Funeral Director; A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (14P) 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

P 0 9 2011

Goldsborough 32. Registrar's Signature

Larke

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Peronica Gascoigne Physician/ AWAUST 10135 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death Howard County General Hospita Howa Columbia 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Gountry Jamaica Days 07-02-1944 Director 087-70-7997 67 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No GA Henry McDonough 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 252 Prominent Loop 30253 United States items? . Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XX No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x1x1 No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** and Mental Hygiene.
Is marked other than "natural raumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Medica1 Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Wellesley Beadle Ruby Myrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Gascoigne - husband 252 Prominent Loop, McDonough, GA 30253 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Crestlawn Mem. Garden: 09-10-2011 Marriottsville, MD 4 Dopation 5 Other (Specify) 21. Sign vule of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ moxic disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year Day signed by the at d be detached fo Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 🖸 Yes 2 X No Other: ျှ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death Certificate: 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tible of atuxent Parkwag suite 202 mo 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZWN Abdo, MD 10910 LITTLE State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] 28722 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ sept. Sr. M. Ruth Gerlach, RSM 201<sup>Year</sup> 1:00PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Funeral Age (In vrs. last birthday) 8. Date of Birth Birthpiac Country) MD Months 1 M 2 M 578-66-7044 1-23-1917 94 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6806 Bellona Avenue 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) Religious College (1-4 or 5+) 4 + Educátion Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ည Jacob Peter Gerlach Rose Catherine Hofman and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Religious if Health Sisters of Mercy Order 101 Belmont, NC 28012-2898 or other Mercy Drive. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Kurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn Cemetery 9-8-2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No jo Day Month Year 1 Yes 2 9 Unknown detached the Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 X No or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 \sqrt{Yes} 2 \sqrt{No} after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year)

Registrar

State

JACKIE JONES,

Date filed (Month War Year)

SEPTEMBER

RUTH GERLACH

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

berson who completed cause of death (Item 23a) (Type, Print)

**CRNP** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 28723 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ YOLANDA MARIE GUERRIERI SEPT. 2011 8:05 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death FOREST HILL 4c. County of Death BOB HOOPER HOUSE HARFORD 5. Social Security Number 9. Birthplace (State or Foreign Country) MASS. **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. 1 M 2 1 F FEB. I1, 1919 92 **Director** 219-28-9603 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 28a-f BEL AIR HARFORD MD 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 1317 SOUTH WELL LANE USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, et-Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ☐ Yes 2 🛣 No WHITE If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EMIDIO SCHIAVI MARY OLIVIARI Department of Health and Important, If item 27 is m. any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 SOUTH WELL LANE BEL AIR, MD 210141317 SOUTH WELL LANE JOANNE PHILLIPS-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/10/11 PARKVILLE, MD MORELAND CEMETERY 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR 21. Signature of Funeral Service Licensee BEL AIR, MD 21014 610 W. MACPHAIL RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence on frany, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe 1 🗌 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes ICE HOUSE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special) completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of after death. Director: After 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

GUERRICA Division of Vital Records,

State

within 2 To the

(Check

29b. Signature ar

eted cause of death (Item 23a) (Type, Print)

medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge of the cause of the caus

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Harvilicz Sept. 2011 Basil 1:30 A Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 501 Maude Avenue Brooklyn Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours March 19,1918 POttsville,PA. Director 1XCX 2 F 204-03-5619 93 show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Brooklyn Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 501 Maude Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

XX Yes 2 No þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💢 No Specify: 3√√ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Steel Fabrication (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pipe Fitter 1.0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helena Monda Mike Harvilicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City of Town, State, Zip Code) 501 Maude Ave.,Brooklyn,Maryland,21225 David Harvilicz/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mardowridge Memorial 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 XX urial 2 Cremation 3 Removal from State 9/12/2011 Elkridge, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral HOme, T. 7250 Washington BLvd., Elkridge, Maryland, 20175 21. Signatur V Funeral Service Licenses Kaufman Funeral HOme, Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is the december 1997). Examine Due to (or as a consequence of). that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate has been also been also be a second to the continuation of the conti 1 Tyes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) September 08,2011

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 0 9 2011

			_	=			<b>k. Ensure All Co</b> Health and Mental		ne	
			State     Registrar		С	ertificate of L		Reg.	2011 2	8725
	Physicia Media		1. Decedent's Name (First, Middle, Last)  John Charle				2. Date Mon	of Death	Day 30 Year	3. Time of Death
	Examir	ner	4a. Facility Name (if not institution, give stree Good Samaritan Hos				r Location of Death  Ore City	4	4c. County of Death N/A	-1
	Funeral	Г	5. Social Security Number 6. Sex		(In yrs. last birthda		If Under 24 Hrs. 8. Date	of Birth th, Day, Year	9. Birthola	ce (State or Foreign
	Director		Usual Residence of Decedent		80 Yrs.		] Dece	th, Day, Year nber 2,	1930  Balt.,	Maryland
	Maryland 8a-f sho tiffied at	Director	Maryland Baltimore		10c. City, Town or Gle	n Arm			100	d. Inside City Limits 1 □ Yes 2 🗗 No
	death with the Maryland ritems 23a or 28a-f show ner must be notified at	Funeral Di	10e. Street and Number 17 Wineberry Court	t		10f. Zip Code 21	057	10g. (	Citizen of What Country United S of Ameri	
တ	dea itel	by Fur	11. Marital Status  1 Never Married 2 Married	Was Decedent Ev Armed Forces? 1 ⚠ Yes 2 □ N If Yes, Give	er in U.S. 1:		ispanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc.		14. Race - American Black, White, etc	Indian,
5-0036	ours after atural", or cal Exami	eted t	3 Widowed 4 Divorced	Year or Dates.		1 Yes 2X No			Specify: Whi	
215	hin 72 h ne. <b>than "na</b> ne Medio	Completed	(Specify only highest grade co		(Gir	DO NOT use retired)	during most of working	16b.	. Kind of Business Indus	
Q 21	filed with al Hygier d other t	Be C	12 17. Father's Name (First, Middle, Last)		4 N	Mechanical	Engineer  18. Mother's Name (First, M.	iddle Maide	Enginee	ring
$\sum_{j} \int_{anyland}$	should be filed within and Mental Hygiene. is marked other tha aumatic event, the I	2	Charles W. Hass				Lydia A	mold	ar Suriame)	
Mar	2 章 4 4		19a. Informant's Name/Relationship (Type, F Catherine H. Peloqui	in/daugh			and Number or Rural Route N ngo Rd. #20 Da			
more	ermt. Page 1 and epartment of Hea mpo tant. If item ny injury or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	20b. Place of Dis cemetery c EVans Chape	position ( <i>Name of</i> rematory or other place Funeral - Bel Air	September 8, 2011	^	Location - City or Town	
Hair	ermit. Pag epartment mpo tant: ny injury e		21. Signature of Funeral Service Licensee	1			ematives Funeral Road Timonium,	and Cr Varylan	emetica Cente d 21093	r, P.A.
- 1			23a. Part I. Enter the disease, or complicati shock, or heart failure. List only one ca Immediate Cause (Final	ons that caused t use on each line.			g, such as cardiac or respirat	ory arrest,	A	Approximate nterval Between Ons 1 and Death
0	Phylician Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):	omp reku	in fracture	WIL	. Couples	tins
	Examine	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):		. 1	1 0	1 (1)	
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to for as a	consequence of):			US	Service Horney Aling	ā
9	e be exe ysician ie burial	<u>a</u>	d	200 10 (0) 43 4 1	oonsequence on.		THE PARTY OF THE P	N NEDICAL EX	B CZYDRYAM NOTACH TRE	
6876	ertificat ding ph se as th	/Mec	IF FEMALE: 23c. I	If yes, outcome of	f pregnancy		- 1			
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the beautified in the funeral director, page 2 should be detached for use as the beautified in the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Physician/Medic	in the past 12 months?	1 D Live Birth 2 4 D Pregnant at t 9 D Unknown	Fetal death 3 time of death 5	☐ Ectopic pregnand ☐ Other (specify)	by	_	23d. Date of delivery Month Da	ay Year
, P.O.	es that the igned by be detained		Part II. Other significant conditions contributions Contributions	0	t not resulting in the	e underlying cause giv	ven in Part I. 23e.		o use contribute to the	
ords	v require s been s should	Completed by	Hyper fine	O Fil	will he	•		1 Yes Was an	24b. Were autopsy	bly 4 Unknown y findings available
Division of Vital Records,	The lav	Comp	777.19		7,0		1 [	autopsy performed? Yes 2	death?	pletion of cause of
/ital	sician: s certific	To Be	25. Was cas erred to medical examine?  1 ✓ Yes 2 ☐ No  Hospi	ital:	1 0 T T T 1 0 1 1 1	Othe	ace of Death (Check only one			
of)	ng Phy fter this ineral d	ite: T		28a. Date of injury (Month, Day,		of 28c, Injury	?		ury occurred	
sion	Attendi death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Unk.	<u>Uni</u>	M 1 🗆	Yes 2 No ta	tion (Street s	om not and Number or Rural Ro	oute Number
Divi	ital or / irs after ral Dire		4 ☐ Homicide determined	building, etc.	(Specify)		City	inebe	ite)	n Arm IND
20	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Examiner: C	On the basis of exa	mination and/or inv	estigation, in my opinio	, date and place, and due to t on, death occurred at the time, e time, date and place, and due	date and plac	ce, and due to the cause	
00	Within To the Committee of the Committee	-	29b. Signature and title of certifier							
	3		30. Name and address of person who complete	eted cause of dea	ath (Item 23a) (Type	, Print)	aven Boulo	10	2.11	111
	Stat		31. Date filed (Month, Day, Year) SFP 0 9 2011	3 Registrar	s Signature	arked	aver 1206/10	KINE	The fines	VR, Mayla
	Registra	ar	SEP U 8 ZUIT	Keyens	p. 19	W. C				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Hammo		1- For State Registrar	Maryland / Depar	rtment of tificate of		Mental H		201 eg. No	1 28726
Physici Medical Exami		Decedent's Name (First, Middle, Last)     CHARLES WILLIS	HAMMOND SR				2. Date of Deal Month Septembe	Day Year	3. Time of Death 1840 hrs
		4a. Facility Name (if not institution, give st Gilchrist hospice			b. City, Town, or Lo	ocation of Death		4c. County of D Baltimore (	
Funeral Director		5. Social Security Number 6. Sex 220-03-3234 XX M	7. Age (In yrs. las 2 F 92	st birthday) Yrs.	If Under 1 Year  Months Days	If Under 24Hrs Hours Min	-		o. Birthplace (State or oreign CAARRY) LAND
and shnw any nce.	or	Usual Residence of Decedent	_ · · ·	Fown or Location	on				10d. Inside City Limits 1 Yes 2 XXVo
with the Maryland 18 23a nr 28a-f shn e notified at once.	Director	10e. Street and Number 615 CHESTNUT AVENUE			10f. Zip Code 21204		10	Og. Citizen of What USA	Country?
215-0036 be filed within 72 hours after death with the Maryland nual Hygeine. rked other than "natural", or items 23a nr 28a-f shi ent, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 Married 3 Widowed 4 XXDivorced If Y	2. Was Decedent Ever in U.S Armed Forces? XX Yes 2 No I I	If Ye	s Decedent of Hispa es, specify Cuban, M Yes 2 XXNo	Mexican, Puerto		14. Race - A White, et	merican Indian, Black, tc. WHITE
136 thin 72 hours a te. than "natura edical Examira	Completed by	15. Decedent's Education (Specify only h Elementary/Secondary (0-12)	Dates: iighest grade completed)  College (1-4 or 5+)	during mo	's Usual Occupation st of working life. D	OO NOT use reti	red)	16b. Kind of Busine	
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medical	Be	17. Father's Name (First, Middle, Last) CHARLES SKELTON HAMI	· · · -		18	.Mother's Name HELEN JI	(First, Middle, N EANESS (	Maiden Surname) CANNEN	
MD and 2 sho salth and 27 is raumati		19a. Informant's Name/Relationship (Type CHARLES WILLIS HAMMO 20a. Method of Disposition	OND JR SON	15207		ES DRIVI		RS FL 339	908
Baltimore, A permit. Pages I and Department of Health Important: If item injury or nether trau		1 Burial 2XX Cremation 3 4 Donation 5 Other Specify: 21 Signature of Funeral Service vicensee	Removal from State Cr	ematory or oth ENMOUNT	er place) CREMATOI	RY 09/0	05/2011	BALTIMORI	E, MARYLAND NERAL HOME INC
Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each I						MARYLAN	Approximate Interval Between Onset and
/Medical Examiner			ad Injuries complicate to (or as a consequence of)		tensive athero	sclerotic car	diovascular	disease	Death
ted Insit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence of)						
50, te be executed ysician and burial - transit	edical	UNPENDED	MENDED						
ion of Vital Records, P.O. Box 68760, treading Physician: The law requires that the death certificate be death.  tion: After this certificate has been signed by the attending physicy the funeral director, page 2 should be detached for use as the burn	Physician/M	past 12 months?	3c. If yes, outcome of pregna Live birth Pregnant at time of deal	2 Fet	al death 3 er (Specify)	Ectopic pregna	ncy	23d. Date of del Month	ivery Day Year
P.O.	á	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.			e to the cause of death?  Probably 4  Unknown
Division of Vital Records, P tal in Attending Physician: The law requires t rs after death.  al Director: After this certificate has been sign led in by the funeral director, page 2 should be e	Completed	25. Was case referred to medical			26 Binne et	Death (Check of	24a. Was a autopo perfor	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 No
n of Vital ding Physician . After this cert funeral directo	on: To Be	examiner? 1 ✓ Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of In 0000 hrs	3 DOA Ot	her <sub>4</sub> Nursin	g Home 5 🔲 I	Residence 6 🗸 Cook injury occurred ck head	Other: Scene
	Certification	Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) Nursing Home 1 Towns (Specify) Nursing Home 1							
Divis To the Hospital nr A within 24 hours after To the Funeral Dire completely filled in b	Medical C	one) 2 Medicai Examiner: On	To the best of my knowledge the basis of examination and manner stated.						
	Mc	29b. Signature and title of certifier	est.	3	29c. License r O.C.M.			29d. Date signed September 2,	
12			nt Medical Examiner	900 W. B	altimore Street	, Baltimore,	MD 21223		
St Reaist	ate	31. Date filed (Month Day Year)	32. Registrars Signature	ale					

State of Maryland / Department of Health and Mental Hygiene T - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 6:05 P M September 6. Billy Fred Hageman Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 6101 Springwater Place #1204 Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Months Hours (Month, Day, Year) Director 577-32-4787 Usual Residence of Deced 1**X** M 2 □ F May 24, 1928 Texas 83 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location Director event, the Medical Examiner must be notified 1 Yes 2X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 21701 USA 6101 Springwater Place #1204 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1X Yes 2 No
If Yes, Give Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes X No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Date \$950-53 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r. National Security Elementary/Secondary (0-12) College (1-4 or 5+) Agency Equipment Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Elizabeth Blake Roy L. Hageman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6101 Springwater Pl. #1204 Frederick, MD 21701 Caroline E. Hageman/wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 09/09/11 | Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUROENDOCUNE CARCINOMA disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, DIABETES MELLITUS, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown of Vital Records. Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DIVERTICULOSIS autopsy performed? Yes 2 No death? 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier 29d. Date signed (Month, Day, Year) one Lon Mo 221936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 FREJERICK MU 2170Z THOMAS VOHNUON OR A. WONEUSON MO 65C 31. Date filed (Month, Day, Year) State SEP 0 9 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Armand Joseph Hardy 2011 September 11:17 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 19126 Capehart Drive Montgomery Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Sept. 8, Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F <sup>4</sup>1946 New York **Director** 64 <u>221–30–1615</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD Montgomery Montgomery Village 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral with: items 23a 19126 Capehart Drive 20886 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 Black, White, etc. ō þ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1970 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Warehousemen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be: Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. မ Florence Marie Valliere Eugene Leonidas Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19126 Capehart Drive Montgomery Village, MD 20886 Irene Theresa James/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/07/11 Woodbine, MD 4 Donation 5 Other (Specify) Signa e of Funeral 🛠 Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician Tongue Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or lingury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performe death? after death.

Director: After this certificate 1 Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2X No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State Hospital within 24 hours a Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year September 3, 2011 D37142 son who completed cause of death (tem) 23a) (Type, Print)
eman, M.D. 1355 Piccard Dr. Rockville, MD 20850

State Registrar

HMH 17 Rev 7/2009

30. Name and address of

31. Date filed (Month, Day, Year)

Geoffrey Coleman, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alfred Samuel Hawley, Jr. September 2011 10:40P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton 550 Middle Road 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Min. (Month, Day Year) 218-54-0309 Director Maryland 62 Dec Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2X No MD Cecil Elkton r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 550 Middle Road 21921 USA death ral", or item 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Construction traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ Alfred Samuel Hawley, Sr. Mildred Margaret Kinzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Christopher Samuel Hawley/son 53 Longview Avenue North East, MD 21901 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crematory 09/05/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Ser Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Metastatic Colon Cancer Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): by the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month signed by the ar 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available certificate has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 Tyes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Il Director: After to in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct

completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Richard Schraeder, M.D.

0 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D66049

7501 Osler Drive Towson, MD 21204

29d. Date signed (Month, Day, Year)

September 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month OlaMae Jackson 1090 920 261 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (In vrs. last birthday) **Funeral** Months Hours Min 1 M 2 X F 240-40-9725 Yrs. **Director** 81 7/1929 NC Usual Residence of Decedent 28a-f show 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4058 The Alameda 21218 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th N/A Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mamie Lee Long James Allen Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4058 The Alameda Baltimore, MD 21218 Jeannette Jackson-Daughter altimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) on Forest 9/7/2011 Owings Mills, MD 22. Name and Address of Facility March F/H 1101 E. North 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Examin Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown Yes 2 No the 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nhknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Yes 1 Inpatient 2 ER/Outpatient 3 DOA anner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending work' 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month. Day, Year) D0038956 8 29 Loch Raven 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> Physician/ Month 3, Sept. 5:30A. Mary Jordan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Larkin Chase Nursing Home Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 03-28-1924 PA 87 Director 185-12-9956 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🏝 No Prince George's Bowie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20716 15005 Healthcenter Drive · death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. "natural", or ite Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify: 3 A Widowed 4 Divorced Completed White , be filed with.
Mental Hygiene.
•d other than "natu.
•t the Medical Ey 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Martin Marietta Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ည Irene Mohler permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. John Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12609 Crumwick Lane, Brunswick, Maryland 20715 Robert Jordan, III - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Meadowridge Mem Park | 09-07-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at f Funeral Service Licen 21. Sign yur MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, i i n disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each nours after death.
 Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year led by the a detached f P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 10 မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете To the l within 2 To the F only one 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month orner 115 PM rene BR' 1105 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cours montgomer 10404 Spring eslie Silver Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday, Year If Under 8. Date of Birth 1 □ M 2 🗶 F Hours Min. 398-10-7191 Mar<sup>Month</sup>1<sup>D</sup>2<sup>y</sup>, Year)919 Wisconsin Director 92 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 20902 10404 Leslie Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give. 1045. 4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ō, 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 XWidowed 4 Divorced Specify: White Year or Dates. 1945-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Powers Eugene Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10404 Leslie Court Silver Spring, MD 20902 Marcia Ann Joiner/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o ō cemetery, crematory or other place 1 

Burial 2 

Cremation 3 

Removal from State Final Journey Crematory 09/08/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signal of Funeral S Going Home Cremation Service P.O. Box 784 MO1251 Beverly L Heckrotte, P.A. Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ stage renal Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes Other: 2 **N**No 5X Residence 6 - Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of : After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation Director: Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert

State Registrar

DHMH 17 Rev 7/2009

berson who completed cause of death (Item 23a) (Type, Print)

1355

MD

oleman

31. Date filed (Month)

29c. License number

37142

Piccard Dr Rockville

29d. Date signed (Month, Day, Year)

VO-5011

<sup>′</sup>)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 0 9 2011

32. Registrar's Signature

RES-000

2011

SEPTEMBER 5

4940 Eastern Avenue, Baltimore, MD, 21224

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

awara Johnson	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No. 2011	28734
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month	Time of Death
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Good Samaritan Hospital  4c. County of Death  Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Foreign	
	Usual Residence of Decedent	m Virginia
nd how any cc.	Maryland Baltimore Parkville	Od. Inside City Limits Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f showmanic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number  1801 Wentworth Rd.  10f. Zip Code  10g. Citizen of What Country 21234-	?
r death with the or items 23a const be notified.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	n Indian, Black,
s after deat rral", or its	3 Widowed 4 Divorced IT set give year 1 Yes 2 No specify: Specify:	cK
72 hours a fragura	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Fercing College (1-4 or 5+)	
5-0036 led within 72 hour tygiene. other than "natu the Medical Exan Completed	Laborev  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	mpuny
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	William Johnson Ruby Stone	0.10.022201
and 2 should be filed within 72 hours after teath and Mental Hygiene.  ten 27 is marked other than "natural", ir raumatic event, the Medical Examiner  To Be Completed by F	Laura Johnson -daughter 3006 Krouse St. Richmond, Vigil	nia 1
ages 1 an nt of Hea nt: If iter other tr	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory  9/8/11  Cations ville	. A A A
Baltimore, MD 21215-C pernit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the I To Be Co	21. Signature of Funeral sice Licensee 22. Name and Address of Facility a expression of the state of Facility and the state of Facility and the state of Facility and Facility	A, 21729
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical £xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Complications of Esophageal. Carcinoma  Due to (or as a consequence of):	Death
<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
red Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
60, ate be execute hysician and e burial - tran	d.    X UNPENDED   AMENDED 23a,27,per me,g920 10-20-11 sm	
ox 68760, eath certificate be attending physici for use as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
he death certification by the attending place as the Ched for use as the Physician/A	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P. C. I that deta	1 Yes 2 No 3 Probab	
Records, I : The law requires ficate has been sig ; page 2 should be Completed	24a. Was an autopsy prior to com	sy findings available pletion of cause of
		2 No
f Vital Physician er this cert and directo	1 V Yes 2 No 1 I Inpatient 2 EN/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:	
ion tendin tor: A the fu	1 Natural 5 Pending 2 Accident Investigation	
Division of spital or Attending Phrours after death.  neral Director: After tilled in by the funeral Certification: T	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	Route Number, City
Divis  To the Bospital or At within 24 hours after d To the Funeral Direct completely filled in by Medical Certifica		ause(s)
To with To Con		Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	
State	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month, Day, Year)  32. Registrar's Signature	
Registrar		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Yea William Kolarek DTP M. DP Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death N/A If Unic Security Number Age (In yrs. last birthday) **Funeral** Sex 1X☐ M 2 ☐ F If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign <sup>Year</sup> 19<u>28</u> Months Days Sept 14 Hours Min Maryland 82 213-28-2838 Yrs Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funera 707 Maiden Choice Lane Apt. 7211 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Kolarek Frances Luza permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Heinbauch, Daughter 6109 Kyle Leaf Court Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place injury ( 4 ☐ Donation 5 ☐ Other (Specify) 09/09/11 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licens & Thomas Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Gregor any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ulmonary disease or condition resulting in death) Omin Medical Due to (or as a consequence of): Examine 90 mins Sequentially list conditions. Examine Duri to (or ea a consequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed ardioni that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P. 1 ☐ Yes 2 ☐ No 3 🍽 Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 DONo မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) sciles 50 H72243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Baltmore, 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryl	•			nd Mental Hy	giene	
			State Registrar	Cer	tificate o	of Death		Reg. No	1 28736
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		3. Time of Death
J	Medic	al	Christopher J. Kessler, Jr.				Septem		<sup>year</sup> 0930 <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)			n, or Location of	Death	4c. County of Palti	
	C.maral		114 Nunnery Lane Apt. A  5. Social Security Number   6. Sex   17. Age (In v.)	rs. last birthday)	Catons If Under 1 Ye		4 Hrs. 8. Date of Bird		9. Birthplace (State or Foreign
	Funeral Director		215-22-4161 1X M 2 F 83		Months Da	ays Hours	Min. 08/24/	1928	Country) Marvland
	M		Usual Residence of Decedent						
	yland f sho ed at	[당		City, Town or Lo					10d. Inside City Limits
	Mar 28a- notifij	Director		atonsvil					1 Yes 2 No
	th the	ral [	10e. Street and Number		10f. Zip Coo			10g. Citizen of Wh	
	ath w	Funeral	114 Nunnery Lane Apt. A  11. Marital Status 12. Was Decedent Ever in	U.S. 13. V	Vas Decedent		n? (Specify Yes or No-	United S	American Indian,
(O	or ite	by F	Armed Forces?		f Yes, specify C	Cuban, Mexican,	Puerto Rican, etc.)		White, etc.
93	rs aft ıral", Exal	ed t	1 ☐ Never Married 2 ☐ Married 1 ☐ ☐ Yes 2 ☐ No If Yes, Give Year or Dates. W	VII   1	Yes 2 🔀	No Specify:		Specify:	White
5-0	2 hou "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Ockind of work do	cupation one during most o	of working	16b. Kind of Bus	iness Industry
7	hin 7	E I	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retir	er/Dete		Law Enfo	maement.
5	Hygie Hygie other ont, th	l on h	12 17. Father's Name (First, Middle, Last)	FOLIC	e Ollic		's Name (First, Middle,		rceneric
anc	be file	뎯	Christopher J. Kessler				tia Miller	waiden Surname)	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 'sumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Str		or Rural Route Numbe	r. Citv or Town. Sta	te, Zip Code)
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Darlene Prennan - Daughter		,				Maryland 21228
J.C.	of He			b. Place of Dispo	sition (Name of	f	Date		ity or Town, State
altimore,	Page nent ant: I		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	lantic	,		9/08/2011	Glen Bur	nie, Maryland
Balt	permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanone.		21. Signature of Funeral Service Licensee	22 D	Name and Ad	Idress of Facility	Funeral Hor		
_				5	311 Fdm	ondson /	Avenue Ball	imore. M	aryland 21229
	Physician/ Medical	1	23a. Pall 1. Enter the dise i.e. or complications that caused the d shock, or heart faill e. List olly one cause on each line.	eath. Do not ente	er the mode of	dying, such as ca	ardiac or respiratory an	rest,	Approximate Interval Between
			Immediate Cause (Final disease or condition resulting in death)	1 (0	rojal	<u>, 1)ea</u>	MM		Onset and Death
-	Examiner		Due to (or as a cons		106	Via1	4.0-1		
		je	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons		4000	SIQ 1	Tolter Ct	cort	
1.	ted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury						
3	execu an an rial-tr	ĕ	that initiated events resulting in death) Last    C. Due to (or as a constitution of the constitution of t	equence of):					
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d						
387	rtifica ling pl e as t	/Me	IF FEMALE:	~~~~					
Box 687	ath ce	igu	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time	etal death 3	Ectopic pregr	nancy		23d. Date Mont	of delivery h Day Year
m.	res that the death certifics signed by the attending p d be detached for use as t	Be Completed by Physician/Me	1   Yes 2   No 4   Pregnant at time 9   Unknown	ordeath 5	Other (specif)	//			
P.O.	hat the ed by detac	y P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying caus	e given in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
s,	uires t n sigr ald be	q pe					1 🗆	Yes 2 ☐ No 3	Probably 4 Unknown
010	w require s been si s should I	plet					24a. Was		ere autopsy findings available or to completion of cause of
3ec	Physician: The law this certificate has ral director, page 2 g	E O					— autop perfo 1 ☐ Yes	ormed? de	ath?
e	ian: T	3e C	25. Was case referred to medical examiner?		26	6. Place of Death	(Check only one)		
Ξ	hysic his ce Il dire	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2		t 3 🗆 DOA	Other: 4 \(\sum \) Nurs	sing Home 5 Resid	dence 6 Other	(Specify)
J Of	ling P	Certificate:	27. Manner of Death  1 Natural 5 □ Pending  28a. Date of injury (Month, Day, Year,	28b. Time of injury	v v	njury at work?	I	now injury occurred	
Sior	ttend death stor; / the f	tific	2 Accident Investigation 3 Suicide 6 Could not be	t home farm str		1 Yes 2 N		Street and Number	or Rural Route Number,
Division of Vital Records,	l or A after Direction by	Ser	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	cify)	set, factory, offi	ice	City or Tow		or narai noute ivambei,
	spita hours neral	Medical	29a. Certifier 1 Certifying Physician: To the best of my kn	owledge, death o	occured at the t	time, date and pl	ace, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After thi completed filled in by the funeral	Med	(Check 2 Medical Examiner: On the basis of examine only one) 3 Certifying Nurse Practioner: To the best of						
_	Viith Viith Com		29b. Signature and the organified 716 Maile	choicel	29c. Lic	ense number	7/7	29d. Date signed (	Month, Day, Year)
	(X)		The state of the s			1006	105	9/7/1	1
	5		30. Name and address of person who completed cause of death (I	tem 23a) (Type, F へ <b>ら</b> いした)	,	01(5)	A DAI	TMAP	E WD SISS&
	Stat	e	31. Date filed (Month, Day, Year) 39. Registrar's Signature (Month, Day, Year)		~ CP(		- OAC	711100	0 1110 2101
	Registra	_		1	. 1		,4		

DHMH 17 Rev 7/2009

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Joanne M. Knell 9:45 PM SEP 06 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a ST. AGNES BALTIMORE HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Hours 1 🗆 M 2 🔀 F 1/28/1929 218-24-4651 Marvland 82 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** 1 Tes 2 No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, RGT 232 21228 USA items ral", or item ו Examiner וו 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 2 should be filed within 72 hours after of the and Mental Hygiene. 27 is marked other than "natural", or 1 ☐ Yes 2 💢 No If Yes, Give 5-0036 White 1 Yes 2 No Specify. Specify 3 X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Joseph McGrath Ivy Tubner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Ribble Court, Ellicott City, Maryland 21043 Cynthia L. Fox / Daughter 4706 or other Page 1 and 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ₽ 💆 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 9/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Maryland Lake View Mem. Pk. 21 Signatu of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Hypovolemic Shock Medical Due to (or as a consequence of) Examiner 1 week cellulitio eft lea Securations let conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury approximation executed by the attending physician and stached for use as the burial-transit Meningiosea

Due to (or as a consequence of): that initiated events resulting in death) Last (0 y.eog, Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death NIA NA 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? 2 🗹 No Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PGIY2 Medical resident P25483 09/06/2011 Sti Agnes Hospital, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Priyaa Viswanathan, 9005, Caton Avenue, Baltimore, MD 21229. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 9 2011

DHMH 17 Rev 7/2009

Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Maryland		artment of H tificate of D				1 1	28739
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	uncate or L	Jean I	2. Date of Dea	Reg. <b>2</b> . [		3. Time of Death
	Physicia Medic		Brent Kenneth	Kecken				_ Month	., Day 2		8:20 AM
	Examin		4a. Facility Name (if not institution, give st				Location of Death	1	4c. Co	unty of Deat	h
أسمهوي			8208 Streamwood Dr 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday)	Baltim If Under 1 Year	ore If Under 24 Hrs.	8. Date of Birt	th	g. Bir	thplace (State or Foreign
	Funeral Director				58 Yrs.	Months Days	Hours Min.	(Month, Da			untry) cyland
	M		Usual Residence of Decedent			<u> </u>		July 19	, 195	3 Mai	10d. Inside City Limits
	yland f sho ed at	ctor	10a. State 10b. County		y, Town or Lo	cation					1 √2 Yes 2 □ No
	e Mar r 28a- notifi	jre.	MD 10e. Street and Number	Balt	imore	10f. Zip Code		1	10a Citizer	n of What Co	
	ith th	rall	8208 Streamwood Dr	·ivo		21208			USA		•
	ems arm	⊆ ⊦		2. Was Decedent Ever in U.S	3. 13.	Vas Decedent of Hi	ispanic Origin? (S	pecify Yes or No-	14.	Race - Ame	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		f Yes, specify Cuba I ☐ Yes 2 🛣 No		o rican, etc.,	Sp	Black, White ecify: <b>W</b>	hite
5-0	2 hou "natu edical	plet	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done o	ation during most of wor	rking	16b. Kind	of Business.	/Industry
121	thin 7	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired) aging			Co	ntrac	tual
d 2	led wi Hygik other ent, t	രി	12 17. Father's Name (First, Middle, Last)		Tack	aging	18. Mother's Na	me (First, Middle,			
lan	l be fil lental rked tic ev	T D	Albert Kecken Sr.				Ellen Sm	ith			
Baltimore, Maryland 21215-0036	12 should Uth and M 27 is ma r traumai		19a. Informant's Name/Relationship (Typ Albert Kecken Jr-I		19b. Maili 4713	ng Address (Street a Grand Be	and Number or Ru nt Drive	ural Route Numbe Baltime	er, City or To ore MI	wn, State, Zi 2121	ip Code) 8
re,	1 and of Hea item		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place	ce)	Date	l		Town, State
m	Page nent c ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Mea	adowri	dge Mem P	ark Sep.	6,2011			aryland
Balt	permit. Departr Import any inj		21. Signature of Funeral Service License	32-	2:	2. Name and Addre	ss of Facility Ands Fern	y Road	Lansdo	wne M	of Lansdown aryland 2122
П			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	cations that caused the deat	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
1	Physician/		Immediate Cause (Final disease or condition	Myo canon	1 IN	MERN					Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a consequ		8					5.
	LAGIIIIIOI	-	Sequentially list conditions,	Corrowny	ansay	piper					5 min
	ed nsit	Examine	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or sass consect	unince only						5 ym
	ate be executed only sician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
09	s be e /sicial e buri	dical	L.	d							
876	ificate ng phy as th	Med	IF FEMALE:								
P.O. Box 687	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta	al death 3	Ectopic pregnan	су		23	d. Date of d	elivery Day Year
Bo	deat the at hed fo	ysic	1 Yes 2 No	4 ☐ Pregnant at time of a g ☐ Unknown	death 5 l	Other (specify)					
0	at the		Part II. Other significant conditions con	ntributing to death but not res	sulting in the	underlying cause gi	iven în Part I.	23e. Did	tobacco use	contribute t	to the cause of death?
	ires the signer of the signer	d b	merod rema	my				_ 1 □	Yes 2	<b>K</b> No 3 □ 1	Probably 4 🗌 Unknown
ord	v requ	Completed by						24a. Was		24b. Were a	utopsy findings available completion of cause of
ec	sician: The law r s certificate has b lirector, page 2 s	omp						per	opsy formed? 2 No	death?	
al F	ian: Ti	Be C	25. Was case referred to medical			26. P	lace of Death (Ch				
ξ	Physici this cer ral direc	일	examiner? 1 X Yes 2 \( \sqrt{No} \)	lospital: 1  Inpatient 2			ner: 4  Nursing	Home 5 Res			ecify)
o	ding Ph th. After th funera		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time o injury	wor	Ŕ?	28d. Describe	how injury o	occurred	
ion	tendi	iįįį	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome form of		Yes 2 No	29f Location	(Street and	Number or B	Rural Route Number,
Division of Vital Records,	or Al after Direc	Certificate:	4 Homicide determined	building, etc. (Specify	(y)	reet, ractory, office		City or To	wn, State)	40771007 07 17	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Charle a Modical Evamir	cian: To the best of my know er: On the basis of examination e Practitioner: To the best of	on and/or inve	stigation in my opin	ion death occurred	d at the time, date	and place, a	and due to the	e cause(s) and manner stated
	To the within 2 To the сотрые	2	29b. Signature and title of certifier	2000000	,	29c. Licens	se number				nth, Day, Year)
			30 Name and address of names who	ompleted cause of death (Iter	m 23a) (Type	Print)	3974 MV L		9/	6/11	
			30. Name and address of person who co	2135 SMM	Are	both	MUL	1209		<u></u>	
	Sta Registr		CED N 9 201	32 Registrar's Signa	1 Ba	Man de					
			JEF V V EVI	- 1-1-1-1	170						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ 12:30 AM MARIAN NICE 2011 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County PRESBYTERIAN HOME OF MARYLAND Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth **Funeral** (Month, Day, Days Hours 1 🗆 M 2 🕱 F 177-09-9817 95 1916 Pennsylvania Director Aug Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director Towson Maryland Baltimore County 1 🗌 Yes 2 💢 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 21204 USA 400 Georgia Court items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates and Mental Hygiene.

is marked other than "natur
aumatic event, the Medical! 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Office Secretary permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Sarah Price Nice William Young Kulp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Administrator) 400 Georgia Court, Towson, Maryland 21204 Sue Shea 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Brentwood, Maryland Lincoln Cemetery 9/14/2011 Ft. Signature of Eunete Service Control MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eac line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_ician ecmon, a one week disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? OSternor,5 24a. Was an autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D37016 m.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Kenneth Greene,

SEP 0 9 2011

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

6701 North Charles Street, Suite 4105, Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 6 Physician/ 0550 N eene ainia 2011 0 okmber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Country) 1 □ M 2 € E Months Hours Min 0642 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 Kyes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a Melbou rne 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DQ NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ၉ Major 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5 Other (Specify) ☐ Donation f Funeral Service License 21. Signatur 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PSI disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, day leading to immed cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the phy nding parts se as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Unknown ficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurre Certificate: 1 Natural
2 Accident injury 5 Pending hours after death. uneral Director: A 1 Yes 30 P the f Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by ☐ Homicide determined swo t Hospital within 24 hours a To the Funeral I Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ly one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signat 29d. Date signed (Month, Day, Year) D00118 completed cause of death (Item 23a) (Type, Print) 4105, Baltimele, MD21204 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28742 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HELLE Sep 7 Year UTH 11-27 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death BALTIMORE 4b. City, Town, or Location of Death LOCHERN AUGSBURG LUTHERAN HOME Social Security Number 8. Date of Birth (Month, Day, Year FEB 28 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 - XF Days Country) 214-38-6119 95 **Director** Yrs FEB. 1916 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at oc. City, Town or Location
UPPER MARLBORO 10d. Inside City Limits Director MD PRINCE GEORGES 1 🗆 Yes 2 🗓 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "" any injury or other traumeting." items 23a 9404 GRANDHAVEN AVE 20772 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 1 🗆 Yes 2 🖁 No Specify: WHITE Specify Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
FLORENCE KAISER ည ERNEST LASSAHN 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address Street and Number of Rural Boute Number City & Bouro Stat Mark 200772 RUTH SCHNEPP-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State ☐ Donation 5 ☐ Other (Specify) 9/9/11 BALTIMORE, MD PARKWOOD CEMETERY of Funeral Service Lies 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of). the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical **To the Hospital or Attending Physician:** The law requires that the death certificate be within 24 hours after death. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed THRIVE AILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed . Yes 1 Tes 2- No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other 2 မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my called death occurred. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

selecci

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

29c, License number 1285.95

SMITH

ll

BALTO MA

Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or CountryWash. DC 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, Black 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Laurel, MD 10583 Middleport Ln. White Plains, MD 20695 Approximate Interval Between Onset and Day Year his certificate has been signed by the director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) æ Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending hours after death. the Funeral Director: fd 9-2-11 fd 9:22 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 58th st. and Southern Ave. SE Washington DC. 3 6 X Could not be Suicide determined on the curb 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 Medical 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 3, 2011 ancella 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 32. Registra 's Signature

Registrar

28743

2223 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT. 201<sup>Year</sup> DOROTHY MAE LEMBACH 2116 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE HOSPITAL BEL AIR Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-30-6499 Months Days Hours April 25, 1934 77 **Director** Maryland Usual Residence of Decedent 28a-f show 10a. State 10d Inside City Limits the Medical Examiner must be notified at 10c. City. Town or Location Director Maryland Harford Edgewood 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? 23a Funeral 613 Pier Drive 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc. XX Never Married 2 ... Married by 1 Yes XX No If Yes, Give Year or Dates. 'natural", or 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry American Bearing & 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Power Transmission 12 yrs. N/A Book Keeper and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Jacob Lembach Dorothy M. Ullrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Theresa Braswell (Niece) 613 Pier Drive Edgewood, Md. 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 9-12-2011 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Baltimore, Maryland n Jure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ NEVMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) 32 AD 21 [ MAKOMUN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ Vio
9 ☐ Unknown Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 N 2 1 10 **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes pital:
1 Unpatient 2 ER/Outpatient 3 DOA
28a, Date of injury 28b, Time of 28c, 유 Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natura.
2 Accident ANatural (Month, Day, Year) work 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be hours after deat 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 
Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check To the 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated line DO056296 of person who completed cause of death (Item 23a) (Type, Print) 2 500 Upper Chesapeake Drive Belfir, A Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc, 16b,22 per fh g919 9-9-11 vt
State of Maryland / Department of Health and Mental Hygiene amend #9 Per FH G919 9/13/2011 JH
Certificate of Death
Reg. No. Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Tenput Roosevelt Lindsey 05:00 AM 2011 Medical 4a. Facility Name (if not institution, give these and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital of 5. Social Security Number 6. Se. Bathwore Bathwore Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. County) 7-10-1951 Maryland 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral X** M 2 □ F Months Days Hours Min. 60 **Director** 219-52-8997 Usual Residence of Decedent 28a-f show 10a, State 10b. County or items 23a or 28a-f sho miner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1744 W. North Ave. 21217 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 2121\$-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Manufacturing id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Manufacturin Laborer 12±h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roosevelt Lindsey Ethel M. Biddle and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 oosevet Department of Health ar Important: If item 27 is any injury or other trac Ruth Plenty-Walls 4336 Gilmere Ct. Belcamp, Md 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) site Cremation 8-18-11 Baltimore permit. 21. Signature of Funeral Service Licenses FH., 2PA N. Fulton Ave 22. Name and Address of Facility Joseph H. Brown Jr. Baltimoro Md 21217 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Parcuatic Ph sician/ OCHOCOURCHOWO Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transit and Due to (or as a consequence of): attending physiciar Physician/Medical Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) \_\_\_\_ use 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month the detached 9 Unknown 9 Unknown P.O. sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Substance abuse (alcohol Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No director, the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည in 24 hours after bearing. The Funeral Director, After this of an analeted filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Augist 16, 2011 MD RESUCC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Baltimore YUMUL SINAI Haspital Ily Kristine T. 31. Pate filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

SEP 09

2011

1	1-06	597
L	eroy	Moses

oy Moses			nent of Health and Mental Hygiene	
Dhyajai		1- For State Certific Registrar  1. Decedent's Name (First, Middle, Last)	cate of Death	teg. 140.
Physicia dical Exami			Month Septemb	Day Year 1330 hrs
		4a. Facility Name (it not institution, give street and number) 1710 N. Washington Street	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 214-40-0080 1 X M 2 F 69	Months Days Hours Min.	irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) SC
		Usual Residence of Decedent		
nd thow any	Ŀ	10a. State         10b. County         10c. City, Town           MD         N/A         Balt:	imore	10d. Inside City Limits  1 X Yes 2 No
y MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene.  tem 27 is marked other thao "oatural", or items 23a or 28a-f show fraumatic eveot, the Medical Examicer must be cotified at occe.	Director	10e. Street and Number 1710 N → Washington St.	10f. Zip Code 21217	10g. Citizen of What Country? USA
h with th ms 23a be ootii	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Specify Yes or N     If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	lo- 14. Race - American Indian, Black, White, etc.
	y Fun	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes 2 X No specify:	Specify: Black
hours a	ted by		Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
0036 within 72 ene. er than	Completed	6th N/A De	elivery Man	Pepsi Cola Co.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Heatth and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, Last) Harry Moses	18.Mother's Name (First, Middle Macie McBrid	
MD 21 d 2 should lth and Me n 27 is man	P	19a Informant's Name/Relationship (Type, Print )  Joann McBride	9b. Mailing Address (Street and Number or Rural Route No. 1102 Ashland Ct. Balti	
e, N I and S Health Fitem		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify	ity Cemetery   9/8/2013	Baltimore, MD
Bal permit Depar Impo	4	21. Signature of Fineral Service Leg each	22. Name and Address of Facility March F/Ave. Baltimore, MD 21	1202
Physician /Medical		Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascu		rrest, shock, or heart Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):		
	niner	if any, leading to immediate Due to (or as a consequence of):		
ansi.	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
be executed sician and unial - transi	dical	UNPENDED AMENDED		
Box 68760, e death certificate but attending physical for use as the but	an/Me	past 12 months:	y 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Box e death of the attented for us	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)	
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	by	Part II. Other significant conditions contributing to death but not resulting		tobacco use contribute to the cause of death?  es 2 V No 3 Probably 4 Unknown
Records, The law require	Completed			opsy prior to completion of cause of
Re The icate		25. Was case referred to medical		formed? death? 2 ✔ No 1 Yes 2 No
A 18:19	o Be	examiner?	Outpatient 3 DOA Other University Office 5	Residence 6 🗹 Other: Scene
log P After funera	ion: T		Time of Injury 28c. Injury at Work? 28d. Describe	e how injury occurred
Division of Vital ral or Attending Physician: rs after death.  al Director: After this certified in by the funeral director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)		(Street and Number or Rural Route Number, City State)
Division of Vital To the Hospital or Atteodiog Physiciao: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one)  2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and due to the car rinvestigation, in my opinion, death occurred at the time, dat	
8 # £ #	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	September 6, 2011
2		Victor Weedn MD JD Assistant Medical Examiner	900 W. Baltimore Street, Baltimore, MD 212	223
St Regis	tate trar		1 hours	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald F. McNamara Steptember 2, 2011 3:02 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 212-30-2531 1 🗶 M 2 🗆 F Hours Min. 78 Ma<sup>yon</sup>ti, <sup>Day</sup>1<sup>y</sup>933 Mafyland **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Hanover 1 Tes 2 XXIVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6305 Hanover Road 21076 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 \_2 X No 1 ☐ Yes 2 🔀 No Specify: SpecifyWhite 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sports Memorbelia Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ William J. McNamara Emily Gurnge and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health a
Important: If item 27 is
any injury or other tra Dorotha McNamara/ Wife 6305 Hanover Road, Hanover Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9/3/2011 Glen BUrnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elridge, Maryalnd 21075 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last anding physician and use as the burial-transi Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Chronic Myelocytic Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CARDIOMYOPAThy 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? SeizUNE DISORDER Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) R047324 September 2, 2011

Registrar

DHMH 17 Rev 7/2009

State

6336

CEDARLANE,

Columbia, md. 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BlackFORD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1,5,10e,18&19b Per PHY &FH G919 9/16/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5, Day 2011 Sept. Wayne Richard McGinnis 10:00A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7838 Old Farm Lane Ellicott City Howard 5. Social Security **5900** 220–50–<del>5500</del> **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F 41 Hours Min. Director Delaware Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Ellicott City 1 🗆 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country?
USA Lane 10f. Zip Code Funeral 7838 Old FArm <del>Road</del> 21043 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Yes 2 No
If Yes, Give X
Year or Dates. þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify White "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Phlebotomist Elementary/Seconday (0-12) College (1-4 or 5+) Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carroll McGinnis Stella Snow Snow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Names or Rural Route Number, City or Town, State, Zip Code) 7838 Old Farm Road, Ellicott CIty, Maryland, 21043 Page 1 and 2 sl ment of Health a lant: If item 27 is Mark Molnar/ Life Partner 20a. Method of Disposition 20b. Place of Disposition (Name of Epwort the Company of the Compa permit. Page 1 a Department of I Important: If ite any injury or ot Date 20c. Location - City or Town, State 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/10/2011 Rehoboth Beach, DE 22. Name and Address of Facility Gary L. Kaulman Funeral Nome, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Sepsis disease or condition Medical resulting in death) Due to (or at a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has be lirector, page 2 s autopsy perform Yes filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person

State Registrar

**SEP 09** 

DHMH 17 Rev 7/2009

80 Falls Rd #704

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number Hunder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | 9. Bill Ulpicoco (Month, Day, Year) | Baltimorel uture cou H mune 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1∏M 2□F 68 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov XIX Yes 2 □ No Director Maryland Irvington 10e. Street and Number 10f. Zip Code log. Citizen of What Country? death with UNited States 21223 3032 Strickland Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2√√No Specify: White Specify: 3 Widowed Windowed "natural", Completed other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Painting Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance of and Mental F Hale Gertrude Claude Ellis Mabe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 3032 Strickland Street, Irvington, Maryland, 21223 Gertrude Mabe/Mother tem 20a. Method of Disposition permit. Pages 1:
Department of He
Important: If Iten
any Injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Meadowridge Memorial 9/12/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): Box 68760. attending physician for use as the burla Physician: The law requires that the death certificate be Physician/Medical the ass 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 ☐ Other (specify) P.0. ned by the detached 9 \ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HEAD AND NECK CANCER with 1 X Yes 2 No 3 Probably 4 Unknown Completed DISSECTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Hospital or Attending Injury 1 Natural 5 Pending nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day. Year)

DHMH 17 Rev 1/2001

State Registrar MiD

AWAN

31. Date filed (Meeth; Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2717

HAMMONDS

FERRY RD

0006586

BALTIMORY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Day Milton Thomas Montgomery September .201 Medical 8:55a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3900 Chestnut Road Middle River Baltimore Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Min. OCT. 6 64 Hours Country) 212-48-0891 Director MD Usual Residence of Decedent show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Baltimore 1 Yes 2 No MD Middle River 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? Completed by Funeral 3900 Chestnut Road USA ural", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1X Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White d Mental Hygiene. marked other than "natural", If Yes, Give 3 
Widowed 4 Divorced Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Maintenance Exxon Be 17. Father's Name (First, Middle, Last) h and Mental F 18. Mother's Name (First, Middle, Maiden Surname) မ Harry J. Montgomery Loretta C. Finn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wynetta S. Montgomery/wife 3900 Chestnut Road Baltimore MD 21220 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗎 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview 9/8/11 Crematory: Baltimore MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or cor plications that caus at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Colorectal Immediate Cause (Final Physician/ letastati month disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, Exami the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 2 🗶 No 1 🗌 Yes Division of Vital Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending neral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 714 COOPER Date filed (Month, State SEP 0 9 2011 Registrar

11-06	608
John	McCullough

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John McCullough	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death  Reg. No. 2011 2875
Physician	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
Medical Examine	JOHN W. MCCULLOUGH September 1, 2011 1950 hrs  4aFádilify Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Maryland General Hospital Baltimore N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	218-86-2590 1XM 2F 38 Yrs. Months Days Hours Min. 9/12/1972 Country) MD  Usual Residence of Decedent
any .	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
and f show	MD N/A Baltimore 1 X Yes 2 No
Mary r 28a-red at c	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
or death with the Maryland of them 23a or 28a-f shows them 23a or 28a-f shows the most fired at one.  Furneral Director	2127 Division Street 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
Jeath v	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
safter	
2 hours "natu  Exan	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5-0036 ed within 72 hours afted within 72 hours afted within 72 hours afted with a first standard with the Medical Examine Cormoleted by	$\begin{array}{c c} \text{ leighter largy secondary (6-12)} & \text{ N/A} & \text{ Disabled} & \text{ N/A} \end{array}$
21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medital	
2121 ould be fil ould be fil ould be fil ould be fil s marked itc event,	John W. McCallough
MD and 2 shoulth and 2 shoulth and 2 shoulth and and 27 is a summative.	Sabrina Little - Sister 5721 New Holme Ave. Baltimore, MD 21206
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fland Americal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Date 20c. Location - City or Town, State crematory or other place)
Baltimore, permit. Pages 1 ar Department of Her Important: If the injury or other fr	4 Donation 5 Other Specify: Trinity Cemetery 9/9/2011 Baltimore, MD
Bal permi Depar Impo	21. Signature of Fureral Service Licensee  22. Name and Address of Facility March F/H 1101 E. North Ave Baltimore, MD 21202
Physician IM dical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Cardiac Arrythmia due to biventricular hypertrophy  Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a and mild right ventricular dilatation  Death  Due to (or as a consequence of):
	Sequentially list conditions, If any, leading to immediate Tue to (or as a consequence of):
	If any, leading to immediate  Cause. Enter Underlying Cause (Disease or injury that initiated  C.
DA B TE E	events resulting in death) Last  Due to (or as a consequence of):  d.
50, K. Stormer to be executed burial - transit	x UNPENDED ☐ AMENDED 23a,27,per me,g921 11-7-11 sm
760, icate be physici the buri	
the death certificate the death certificate by the attending phyched for use as the behasician/Me	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)
be deat the deat hed for hed for	1 Yes 2 No 9 Unknown 9 Unknown
P. Grand J. G.	1 Yes 2 No 3 Probably 4 ✔ Unknown
Records, The law requires ficate has been sig yage 2 should be	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Reco	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Reccition: The large certificate harector, page 2	25. Was case referred to medical 26. Place of Death (Check only one)
of Vi Physic rer this eral dir	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Nursing Home 5 Residence 6 Other:
ion of tending Pheath.  tor: After the funeral ation: T	1 X Natural 5 Pending (Month, Day,Year)  1 Yes 2 No
Division of optial or Attending hours after death, uneral Director: Afting it filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di Hospital 24 hours & Funeral 1 rtely filled	
To the Ho within 24 h To the Fun completely	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Party 5 # 5 0	
	Theodor W. King The weed O.C.M.E. OCME September 2, 2011
$\phi$	30. Name and address of person who completed cause of death (item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State	
Registra	JULIAN COMPANY COMPANY

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (7

31. Date filed (Month, Day,

D. 600 R 39-Registrar's Signature 2,2011

ANNAPOLIS, MB

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State		State of M	arylan		irtment of H tificate of L		and Men				
			Registrar  1. Decedent's Name	e (First, Middle, La	st)		001	incate or i	Jean		Date of Death	g. Nd.2 ()		3. Time of Death
	Physicia Medic	al		Winthrop	Mandell					Se	eptembe		2011	0645 a <sup>M</sup>
	Examin	er	Casey Ho		e street and number)			4b. City, Town, o Rockvil		f Death			y of Death	
	Funeral		5. Social Security N	umber 6. S	Sex 7. Ag <b>X</b> M 2 □ F		st birthday)	If Under 1 Year Months Days	If Under 2 Hours		ate of Birth		9. Birthp	place (State or Foreign
	Director		112-30-3 Usual Residence of	121	24 W 2 🗆 1	70	Yrs.			/O/	Month, Day, Y	1940	New	York
	yland -f shov ed at	ctor	10a. State	10b. County		10c. City	, Town or Loc	ation					1	0d. Inside City Limits
	ne Mar or 28a	Director	MD 10e. Street and Nun	Montgome nber	ery	Germ	antown	10f. Zip Code	-		10	a Citizen of	What Coun	1 Yes 2 X No
	s 23a uust be	Funeral	22205 Car	nterfield	l Way			20876			US		Trinat Godin	,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiutry or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2  Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.		lf	/as Decedent of H Yes, specify Cuba	n, Mexican,	in? (Specify Y Puerto Rican	es or No- 1, etc.)	Bla	ce - Americ ack, White, e	etc.
5-0	2 hour " <b>natu</b> edical	Completed	(Spe	15. Decedent's E cify only highest gr			(Give k	ent's Usual Occup ind of work done o		of working	10	_	Business Inc	
7121	vithin 7 jiene. er than the M		Elementary/Second 12	onday (0-12)	College (1-4 or s	5+)	life. DO Contr	NOT use retired)	-		F	IVAC		
pu	filed v tal Hyg d othe event,	To Be	17. Father's Name (								t, Middle, Ma	iden Surnan	ne)	
ızyla	d Men marke matic		Winthrop  19a. Informant's Na				101 14:11				se Webs		0 7:	2(.)
, Ma	and 2 shr Health an <b>tem 27</b> is		Marie W.				22205	g Address (Street Canterf	ield W	Vay Gei	mantov	vn, M	2087	6
Baltimore, Maryland 21215-0036	Page 1 arment of He Harment: If Iter				Removal from State	C	emetery, crem	sition (Name of atory or other place rney Cre	natory	Date y 09/08			- City or To e, MD	·
Balt	permit. Depart Import any inj		21. Signature of Fun	neral/Service Licen	elitte	MO12	51 Be	Name and Addre	ss of Facility Crema Heckr	ation S	Service P.A. (	P.C	. Box	784 , MD 21029
					plications that caused one cause on each line	d the death								Approximate Interval Between
~	Medical	ı	Immediate Cause ( disease or conditio resulting in death)		a. Lung Car		ence off:						-	Onset and Death
	Examiner		Eaqueritially list co	r. Wenner				e Pulmon	ary Di	isease				
	ed sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	nmediate dying	Due to (or as	a consequ	ence of):							
	icate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) I	3	c. Due to (or as	a consequ	ence of):							
90	ate be ohysicia the bur	edical			d									
687	certifica nding p		IF FEMALE: 23b. Was decedent	pregnant	23c. If <u>ye</u> s, outcome							23d D	ate of delive	en/
). Box 687	the death or the atternative ached for u	Physician/M	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1			Ectopic pregnand Other (specify)	;y 					Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	b	Part II. Other signif	icant conditions of	ontributing to death b	out not resu	ulting in the ur	nderlying cause giv	en in Part I.	. :				ne cause of death?
ecor	ne law req e has bee age 2 sho	Completed									24a. Was an autopsy performe		prior to cor death?	psy findings available mpletion of cause of
ta F	cian: T ertifica ector, p	Be C	25. Was case referre examiner?	ed to medical	11					h (Check only		<b>№</b> No	1  Yes	2 L NO
Ž	Physic rthis c ral dire	욘	1 Yes 2 2	<b>X</b> No	Hospital: 1 Inpati 28a. Date of inju		ER/Outpatien	28c. Injur	4 ∐ Nur		5 Residence Describe how			hospice
ouo	ading ath. r: After	icate	1 X Natural 2 ☐ Accident	5 Pending Investigatio	( <i>Month, Da<sub>j</sub></i> n		injury	work	? Yes 2 □ 1	- 1	Describe now	injury occui	reu	
Divisi	cal or Atters after de al Directo	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could not t determined	28e. Place of Injubuilding, etc	ury - At hoi c. (Specify)	me, farm, stre	et, factory, office			ocation (Stree		ber or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 burus after death, within 24 burus after death, To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or investi	gation, in my opinio	on, death occ	curred at the ti	me, date and	place, and d	ue to the cau	use(s) and manner stated.
	To t with To t		29b. Signature and	title of certifier	4			29c. License				_	ed (Month, L	
			30. Name and addre	ess of person who	completed cause of d	eath (Item	23a) (Type Pi	D606	J4		Se	premb	er 6,	ZU11
			Bindu C.	Joséph,	M.D. 6001	Munc	aster 1	Mill Rd.	Rockv	ville,	MD 208	355		
Bindu C. Joséph, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855  State Registrar  SEP 0 9 2011  State Registrar State Regist														

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 28754 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Huah Allison Maplesden September 2011 0225 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 7, 1931 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 **X**M 2 □ F Days Hours **Director** Yrs Illinois 80 578-48-4395 Mar Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring MD Montgomery 1 Tyes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 2002 Hidden Valley Lane 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1949–53 1 ☐ Yes 2 X No Specify: Specify. White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) National Security and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Technicial Writer Agency Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ e 1 and 2 should be it of Health and Ments If item 27 is marked or other traumatic e William Taylor Maplesden Ellen Kathryn Milligan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mildred Maplesden/wife 2002 Hidden Valley Lane Silver Spring, MD 20904 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/07/11 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Myocardial Infarction Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events Congestive Heart Failure attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ☐ Pregnant at time of death ☐ Unknown Day Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform **Director:** After this certificate I in by the funeral director, pag 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 🗌 Yes 2X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 September 1, 2011 30. Name and address of person who completed cause of de tem 23a) (Type, Print) Kshama Garg, M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

SEP 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Claire Murphy Sep 5, 2011 Year 6 30 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia **Brighton Gardens of Columbia** HOWARD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🗷 F Months Days Min Nov 20, 1921 190-12-5115 89 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location Director MD Howard Columbia 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way 21045 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired)

Supervisor (Give kind of work done during most of working than Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Garments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lith and Mental F 27 is marked of traumatic even ဂ Edgar F. White Hilda M. Betz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Burbank Road Longmeadow, MA 01106 Bridget Murphy Daughter other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sep 08, 2011 St. John's Catholic Cemetery Windber, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral 22. Name asi Active alli Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 wie Licensee art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALZHEIMER D1361513 disease or condition resulting in death) 4EAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1  $\square$  Yes 2  $\square$ No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 🗆 No 1 Tyes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED examiner' 1 ☐ Yes 2 ☐ No Hospital Other: မ LIVING 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Hospital or Attending 5 Pending 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the population, used to describe a time units, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

70

31. Date filed (Month, Day, Year)

HARRY LI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

8600 SNOWEN KEVEN

State Registrar

			for State Registrar	State of M	larylan	•	artment d tificate d		and M	, ,	giene Reg. N <b>2 0  </b>		28756
	Physicia Medic		1. Decedent's Name (First, Middle, L	ast) HEN N	lon	MA	N			2. Date of Dea Month		Year <b>0</b> //	3. Time of Death
	Examir	ner	4a. Facility Name (if not institution, gi	pital			Ва	n, or Location o ltimore		•	4c. County o	N/A	
	Funeral Director		5. Social Security Number 6. un¹cnown Usual Residence of Decedent	Sex 7. Ag		st birthday) 4 Yrs.	If Under 1 Y Months D	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birth Month, Day May 24	, Year 957	9. Birthp Coun	place (State or Foreign try) England
	faryland 3a-f show tified at	Director	10a. State 10b. County	N/A	10c. City	, Town or Loc		imore C	City			1	0d. Inside City Limits 1 🏋 Yes 2 □ No
	with the N 23a or 28 ust be not	Funeral Dir	10e. Street and Number 10 North Rock Gl	en Road	<u></u>		10f. Zip Co	21229	)		10g. Citizen of W		
3036	ould be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at		11. Marital Status  1 ▼Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 Yes Give Year or Dates.		If	Yes, specify (	of Hispanic Orig cuban, Mexican No Specify:	i, Puerto l	cify Yes or No- Rican, etc.)	14. Race Black Specify:	White,	
9200-91212	I within 72 hou ygiene. her than "natu t, the Medica	e Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12) unknown	grade completed) College (1-4 or 5	5+)	(Give k life. DC	ent's Usual Oci kind of work do O NOT use reta andyman	ne during most red)	t of workii	ng	16b. Kind of Bus	iness Ind	
Maryland	ld be filed Mental Hi <b>iarked otl</b> <b>atic even</b>	To Be	17. Father's Name (First, Middle, Last Reginald Norman	,				18. Mother		(First, Middle, I Scott	Maiden Surname)		
S	1 and 2 should be of Health and Men item 27 is marke other traumatic	i	19a. Informant's Name/Relationship Diane Whikehart								City or Town, Sta land, Ne		ork 10312
Ē	Page nent c ant: If ury or		20a. Method of Disposition  1 □ Burial 2 🏋 Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State cify)	, ce	emetery, crem	sition (Name o natory or other ematory	place)		/2011	20c. Location - C	-	
Pall	permit. Departr Importa any inju		Λ-	So.	_	29	99 Fred	erick R	≀d.,	Baltimo	ociety c re, Mary	of Ma land	aryland J 21228
m. P	h sician/	is a	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	e. CE1	2 OF	THE	= Lu	NO	5 0	NITH		Approximate Interval Between Onset and Death
	Medical Examiner	Į.	resulting in death)  Sequentially list conditions,	Due to (or as	a conseque	ence of): PTK	1815	70	B	RA1	N		
	and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as	a conseque	Ence of):	CA	GCE	=M	1'A			
2	sate be executed physician and the burial-transit	edical	resulting in death, East	■ d	eh	yds	ral	tion					
. DOX 00	To the propriation of Attending Priysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Directoral After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic preg Other (specif				23d. Date Mont		ery Day Year
as, F.O	quires urat u en signed by ould be deta	by	Part II. Other significant conditions	contributing to death b	_	_	nderlying caus	e given in Part I	l.	23e. Did to			e cause of death?
records,	cate has be page 2 sh	Completed								24a. Was a autop perfor 1 \(\sum \) Yes	med2 de	or to cor ath?	osy findings available impletion of cause of
NICAI	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★No	Hospital:	ient 2 🗆 F	ER/Outpatient		Other:			ence 6 🗆 Other	(Specify)	
	ending r.i. sath. or: After thi he funeral	Certificate: 1	27. Manuer of Death  1 Autural 5 Pending 2 Accident Investigati	28a. Date of inju (Month, Date)	iry :	28b. Time of injury	28c. I	njury at vork?	2		ow injury occurred		
DIVISION	lo the nospital of Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funer		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	City or Towr									
I of	the Fune	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	arse Practioner: To the	examination best of my	and/or investi knowledge, de	gation, in my c eath occurred	pinion, death oc at the time, date	curred at and place	the time, date an e, and due to the	d place, and due t cause(s) and man	o the cau ner as sta	ise(s) and manner stated.
•	Note:		29b. Signature and title of certifier  30. Name and address of person who  A MB A CHEW  31. Date filed (Month, Day, Year)	reta u	r)		29c. Lic	ense number 3/90	ין נ	. 2	9d. Date signed (	Morth, E	Day, Year)
			30. Name and address of person who	None 7	leath (Item :	23a) (Type, Pr	EO W	BALT	MO	NE Si	BALL	0 0	red 2/223
	Stat Registra	te ar	31. Date filed (Month, Day, Year)	32. Registra	ar's gnat	Barke	9					-	

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28757 2011 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Donald T.Nowak **Medical Examiner** 0220 hrs 2011 September 5, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel **Funeral** 5. Social Security Number 378 - 52 - 7187Social Security Numbe 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days Foreign Director Hours 09/26/1947 63 Country)Michigan 1 XM 2 F Usual Residence of Decedent 107 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel item 27 is marked other than "oatural", or items 23a or 28a-f show traumatic eveot, the Medical Examiner must he ootified at ooce. Severn 1 Yes 2 X No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8755 Walton Avenue 21144 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 72 hours after 3 Widowed 4 X Divorced Yes, Give Year Specify: White Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
The mortant: If item 27 is marked other than "satural", fojury or other traumatic eveck, the Medial Examiner. 1 Yes 2X No specify: Armv 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ted Nowak Stephanie Dziurzynski Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lupinos/Ex-Wife 501 Kintop Rd., Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 9/9/2011 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facil Maryland Cremation Services
PO Box1413. Baltimore. MD 2 Marshall 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 203 Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a Peritonitis Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) b. Ruptured Hepatic Cyst Ruptured Hepatic Abscess Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical  $\tilde{\mathbf{x}}$  AMENDED 23b, per me, g922 12-29-11 sm UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ≦ 1 Yes 2 No 3 Probably 4 ✔ Unknown Cirrhosis Completed this certificate has been a director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes Hospital or Atteodiog Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other: ဥ 1 Yes After t 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending within 24 hours after death To the Fuocral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 5, 2011 nd address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 2011 ear Arthur Peabody, Sr. Richard 11:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Casey House Rockville Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Months Hours 110-20-4302 84 California **Director** May Usual Residence of Decedent 28a-f show 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland rector MD Bethesda 1 ☐ Yes 2 🄀 No Montgomery ۵ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 9906 Holmhurst Rd. United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give LT LU Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married þ be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" 3 Divorced 4 Divorced Specify White Completed Year or Dates. W.W. II the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Research Science Biochemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peabody Plattner Haro1d Jewett Caroline Virginia 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halina Yasharoff Peabody/Wife 9906 Holmhurst Rd., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or otl 20c, Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 09/10/2011 Rockville, MD Rapp aramerafacand Cremation Services Signatur of Funeral Y M0153 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PULMONARY FIBROSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day signed by the at d be detached fo Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏋 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 \( \overline{\Delta} \) No 2 🗌 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 XNo Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pendina within 24 hours after death To the Funeral Director: A Accident Investigation М 1 Yes 2 No the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4  $\square$  Homicide determined Medical

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

29b. Signature and title of

31. Date filed (Month, Day, Year)

SEP 0 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GEOFFREY COLÈMAN M.D.,

1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

1355 PICCARD DR. SUITE 100, ROCKVILLE, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D37142

29d. Date signed (Month, Day, Year)

SEPT. 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7C Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death SUNSHINE ACRES ASSISTANT LIVING WHITE HALL HARFORD If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 215-22-1551 1 🗆 M 2 🕮 84 7/3/1927 MARYLAND Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 XNo MD BALTIMORE **JARRETTSVILLE** 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 4020 SECURITY LANE <u>21084</u> USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iten Examiner Race - American Indian, Black, White, etc. Armed Force þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify "natural", Specify: WHITE Completed 3X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CLAIMS PROCESSOR INSURANCE ulth and Mental Hygie 27 is marked other r traumatic event, ti 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ THOMAS MOONEY MARIE KNIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ELISE WILDE/DAUGHTER 4020 SECURITY LANE JARRETTSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State DULANEY VALLEY MEM. 4 Donation 5 Other (Specify) CAPDENS 9/9/2011 COCKEYSVILLE, MD 21. Signature of Funeral Sevice Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to Examine Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō the past 12 montl Dav 5 Other (specify) Pregnant at time of death be detached the 9 Unknown 9 🗌 Unknown P.O. á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to - dica Be 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Director: After this funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 \sum Yes 2 \sum No 5 Pending injury Μ Accident Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** :20 AAN 201 100 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Morningside Baltimore Parkville 5. Social Security Number 8. Date of Birth (Month, Day, ) 3/4/1921 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Year) 1 ☐ M 2 ☐ Months 213-16-517 90 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 South Beechfield Avenue USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23s may injury or other traumatic event, the Medical Examiner must Funeral 21229 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy Porstman Pauline Schmidt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne D. Rice / Daughter 12124 Philadelphia Road, Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Church Cemetery 9/12/11 Forest Hill, Maryland □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 1. Signature of Funeral Service Lipensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 111/2005 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine with 000 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and I for use as the burial-transit 2000 Due to (or as a consequence of): 1/2000 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 month Day Year 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page, performed 2 paro or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) An orning Sic 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA <u>L</u> funeral 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director; upletely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after the Hospital 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exam within 24 P. CLMP, MA 29c. License number 29b. Signature and title of control 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of

ustina

SEP 0 9 2011

DHMH 17 Rev 1/2001

Digital or & G. Linkticum mo 4580

705

completed cause of death (Item 23a) (Type, Print)

-010

32. Registral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 28761 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Louise, Papadakis 5:15 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lochearn Future Care Baltimore Baltimore Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Month, Day, Year) une 26,1917 1 M 2 G Months 218-12-6855 94 Director June Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 X No MD 10e. Street and Number 10g. Citizen of What Country? ច 10f. Zip Code 'natural", or items 23a or dical Examiner must be I 918 Hooper Avenue Apt E 21229 USA Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married Yes 2XXNo Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 😾 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Sacks Louise Fousek Spedden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Weber-Daughter 2926 Nova Scotia Road, Bel Air Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 

Donation 5 

Other (Specify) cemetery, crematory or other place) Glen Haven Mem Garden's Sep. 7, 2011 Glen Burnie Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final et and Death Week Aspiration pneumonia Ph si ian disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ dementia, dusphagia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dフ0334 Softenber 4, 2011 MD

State Registrar 31. Date filed (Month, Day, Year) 32.

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lijkn Zhou

2835 Smith Avenue, Suste 203\_ Baltimore.

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N.Z. O State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:00AM ANNE MARY QUAGLINE 2011 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS Baltimore County Timonium 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Yea New York 97 107-07-1201 Director Dec Usual Residence of Decedent show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City. Town or Location within 72 hours after death with the Maryland Director Timonium 1 Yes 2 X No Baltimore County Marvland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21093 2300 Dulaney Valley Road "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 X Never Married 2 - Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Year or Dates White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Aviation Administration Secretary of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ild be file Mental F Frattini Angelo Leonardo Quagline Martina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8217 Bellona Avenue, Towson, Maryland 21204 Penelope P. Hopkins (Niece) Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If its any injury or of ō 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 9/8/2011 Baltimore, Maryland Signat wo Fund Serve De s Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician asi Medical resulting in death) Due lo (or as a consequence of Examiner Sequentially list conditions Examine it any leading to inmediate cause. Enter Underlying Due to jor as a conse, uence of Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No be detached for Month Dav Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate I 1 Yes 2 No 1 Yes 2 XNo Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2011

Registrar DHMH 17 Rev 7/2009

SEPTEMBER

QUAGLINE

ANNE

DULANEY VALLEY ROAD,

2300<sup>1</sup>

32. Pagistrar's Signatus

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

M.D.

ERNESTINE WRIGHT,

Year)

ember

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8.38 A M Medical otem bei Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NIA If Under 1 Year MAge (In yrs. last birthday)

Ole Yrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 1 🗆 M 2 🗶 F **Director** 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 No ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. , or Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 Divorced Specify: Black "naturaf" Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) ollege (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Un Known မ Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harrison - Niece Annie Mn 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If its any injury or ot once. Burial 2 Cremation 3 Removal from State Baltimore, MC 4 Donation 5 Other (Specify) 21. Signature of Funeral pervice Licenses 1101 E. North 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ SCHEMIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any leading to improcleus cause. Enter Underlying Physician/Medical Examine Dunito (unas a consequence or): Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed DIABETES burial-trans and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \square Yes Hospital 2 X No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1- State of Maryland / Departm Registrar Amend Item 2,26 per dr.,g919,09/	ment of He <b>09/2011d</b> cate of De	alth and M <b>hb</b> eath	ental Hygi	ene g. N2 0 1 1	28764
	Physicia Medic		Decedent's Name (First, Middle, Last)	nsay			08/21/201 Day Year	1 3. Time of Death
	Examin			. City, Town, or Lo Glen Burn			4c. County of Dear Anne Arus	
	Funeral Director		214 64 5991 1 PM 2 0 F 50 Yrs. Mo		f Under 24 Hrs. Hours Min.	8. Date of Birth 12/21/1		thplace (State or Foreign untry) Maryland
	should be filed within 72 hours after death with the Maryland dand Montal Hyglene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or a must be notified at aumatic event, the Medical Examiner must be notified at	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Arundel  10c. City, Town or Location  Glen Burnie	Of. Zip Code		11	Dg. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 [X] No
	th with the ms 23a of must be	ineral	202 Poplar Avenue	21061	. 0: ::0/0		United Sta	ates
-0036	should be filed within 72 hours after death with the Maryland is and Mental Hyglene. It is marked at Hyglene than "natural", or items 23a or 28a-f sho is marked or they than "natural", or items 23a or 28a-f sho is marked the Medical Examiner must be notified at raumatic event, the Medical Examiner must be notified at	δ	1 ☐ Never Married 2 🖾 Married 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes, Give Year or Dates.  If Yes, If	yes 2 No S		lican, etc.)		e, etc. erican Jian
21215	vithin 72 h piene. er than "ne the Media	Completed	(Specify only highest grade completed) (Give kind of	of work done duri OT use retired)	ing most of workin	g	16b. Kind of Business Heavy Fqu.	
Baltimore, Maryland 21215-0036	Jube filed v Jental Hyg Irked othe Itic event,	To Be	17. Father's Name (First, Middle, Last) Richard Ramsay, Sr.	18	8. Mother's Name Margare			
, Mary	ge 1 and 2 should be it of Health and Men I if item 27 is marke or other traumatic						City or Town, State, Zi Maryland	
imore	permit. Page 1 and 2 sh Department of Health ar Important; If Item 27 is any injury or other trau		20a. Method of Disposition  1	ry or other place)			20c. Location - City or Jessup, Ma	
Balt	permit. Departi Import any inj				ber Fune ter Stre	ral Home et Balti	es P.A. Imore, Mar	yland 21231
7	Physician/ Medical Examiner		(3a. Par) 1. Enter the disease or complications that caused the death. Do not enter the stock, or heart failure. List only one cause on each line. Immediate Cause (First disease or condition resulting in death)  a. Due to (or as a consequency of):				2V/C	Approximate Interval Between Onset and Death
	cate be executed physician and s the burial-transit	dical Examiner	Secure tally list concilion if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):					
. Box	ath certificate attending phy for use as the	Physician/Medi		topic pregnancy her (specify)			23d. Date of de Month	blivery Day Year
ls, P.O	requires that the de- been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underl	rlying cause given	in Part I.	23e. Did tob	acco use contribute to	o the cause of death? Probably 4 🗌 Unknown
Reco	The law ate has page 2	Completed				24a. Was an autops perforn	y prior to ned? death?	utopsy findings available completion of cause of
Vita	Physician: this certifical	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Other	e of Death (Check	F 20.21	nce 6 🗆 Other (Spe	cify)
Division of Vital	ling After funer	Certificate:	Z = Accident _ investigation	28c. Injury at work? M 1 \(\sum Yes	t 2 s 2 $\square$ No	8d. Describe how	w injury occurred	
DIVIS	spital or Attendours after deathers leral Director; /		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	factory, office	2	8f. Location (Str City or Town,	eet and Number or Ru . State)	ıral Route Number,
	the Hos hin 24 h the Fun npleted	Medical	29a. Certifier (Check only one)  1 ertifying Physician: To the best of my knowledge, death occur only one)  1 ertifying Physician: To the best of my knowledge, death occur only one)  2 Medical Examiner: On the basis of examination and/or investigation of the best of my knowledge, death	on, in my opinion, occurred at the tire	death occurred at t me, date and place	the time, date and e, and due to the	d place, and due to the cause(s) and manner as	cause(s) and manner stated. s stated.
D	E III O		29b. Signature and title of certifier	29c. License nu	200696	62	OB 2	2/11
\ 				115 RX	trhiet	tighting	Brookly	mp 21225
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 9 2011 Security B. Sea	Med				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7.8 per fb g919 9-13-11 vt State of Maryland / Department of Health and Mental Hygiens O. 1.1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Scotember ter man 7 2011 ume /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Sept Qay, Year 1924
Feb. 29 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 **X**M 2 □ F 212-20-6498 Maryland Yrs. 87 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Baltimore Baltimore MD 1 ☐ Yes 2 X No Director must be notified 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ö USA 21224 7051 Eastbrook Avenue 23a Funeral death v items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ XSo Specify: þ Specify: White 3 XWidowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 1st Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Safranek John Rumel ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7051 Eastbrook Avenue Baltimore MD 21224 Margaret Ourednik /sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bonemian National 9/9/11 permit. Page:
Department o
Important: If
any Injury or
once, Baltimore MD 4 Donation 5 Other (Specify) 21. Signature I Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory
Due to (or s a consequence of): **Physician** Failure Iweek /Medical **Examiner** Stage Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead to the cause) Examiner Due to (or as a consequence of) physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes death. 2 No nours after death.

neral Director: Af 2 Accident 6 Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i Hospital 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D71735 September 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singe Benjamin David 4940 Eastern Avenue, Baltimore, MD, 21224 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	Marylan		artmen			and M			201		2876	5 6
	Physicia	in/	Registrar  1. Decedent's Name (First, Mid  Angela T	idle, Last) Rizzo		Cer	liiicali	<del>J</del> OI L	eaur		2. Date of De			Year	3. Time of Dea	
	Medic Examir	cal	4a. Facility Name (if not instituti		)		4h City	Town or	Location of		Sept. 4		2011		3:53 A	М
*****	Exami	lei	Gilchrist	on, give street and namber)				Town, or		oi Death		4	c. County o	timo	ore	
	Funeral Director		5. Social Security Number 213–28–0445	6. Sex 7. A	Age (In yrs. Ia		If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birth	place (State or Fo	oreign
			Usual Residence of Decedent	t	78	Yrs.					Sept 25	5, 1	932		cyland	
	laryland 3a-f sh ified af	Director	MD Ba	1timore		y, Town or Loc nsdowne								1	0d. Inside City Li 1 ☐ Yes 2	
	a or 28 be not		10e. Street and Number				10f. Zip	Code				10g. C	Citizen of Wi	hat Cour	ntry?	
	ath with	Funeral		n Drive	+ F i - 11 C	140.11		227	. 0:	: 0.10	:: V N		US			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 🔀 M 3 □ Widowed 4 □ Divorc	Armed Forces		l II	Yes, spec	ify Cubar	n, Mexican	gin? (Speci i, Puerto F	cify Yes or No- Rican, etc.)		14. Race Black Specify:	, White,	etc.	
15-(	72 hou In "nat Medica	Completed	(Specify only hig	dent's Education ghest grade completed)		16a. Deced		k done di	ition uring most	of workir	ng	16b.	Kind of Bus			
212	l within /giene. <b>ner tha</b> <b>t, the J</b>		Elementary/Secondary (0-12		r 5+)	Cleric		reared)				Sta			ryland	
Baltimore, Maryland 21215-0036	uld be filed Mental Hy narked ott natic even	To Be	17. Father's Name (First, Middle Francis Rays	inger					18. Mothe The	er's Name eresa	(First, Middle, Puls	Maider	n Surname)			
, Mar	nd 2 shou lealth and m 27 is n		19a. Informant's Name/Relation Phillip M Riz			2109	Gay1	awn :			Route Numbe					
timore	Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 🎇 Burial 2 □ Crematic 4 □ Donation 5 □ Other	on 3 Removal from Stat	Ho1	lace of Disposemetery, crem y Cross	sition (Nam natory or ot S Cem	ne of ther place eter	y S		ate 3,2011		Location - Cooklyr	-		
Bal	permit Depar Impor any in		21. Signature of Funeral Service	e Licensee	(						rose Fu Road A				nc. and 2122	27
ببشور	Ph_sician/		Immediate Cause (Final	or complications that cause at only one caus, or each lin	ed the death ne.	n. Do not ente	r the mode	of dying	, such as o	cardiac or	respiratory arr	rest,			Approximate Interval Between Onset and Deat	
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as	s a consequ	ence of):	<u>au</u>	CeJ						+		
	ted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as	s a consequ	ence of):										
0	ate be executed hysician and the burial-transit	dical Ex	that initiated events resulting in death) Last	C. Due to (or as	s a consequ	ence of):										
8760	tificate ng phy e as the	Medi	IF FEMALE:	d											_	
. Box 687	or Attending Physician: The law requires that the death certificate be executed iffer death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi		23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal at time of de	I death 3	Ectopic p Other (spe						23d. Date Mont		ery Day Year	
Division of Vital Records, P.O.	requires that the der been signed by the s should be detached	by	Part II. Other significant condi	tions contributing to death	but not resu	ulting in the ur	nderlying c	ause give	en in Part I.		23e. Did to		<b>S</b>	_	e cause of death	
Recor	s <b>ician:</b> The law re certificate has be lirector, page 2 sh	Completed					-				24a. Was a autop perfor		pri de		osy findings availa npletion of cause 2 🏻 No	
/ita	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:		ER/Outpatient	2 🗆	Other	ce of Death				N		Hospic	. 0
27. Manner of Death 1 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 1 Natural 2 Natural 2 Natural 2 Natural 2 Noticide 3 Suicide 4 Homicide 28a. Date of injury 28b. Time of injury 3 Nother (Specify) 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28b. Injury at work? 1 Nother (Specify) 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28b. Injury at work? 1 Nother (Specify) 3 Suicide 4 Homicide 4 Homicide 28c. Injury at work? 1 Nother (Specify) 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28c. Injury at work? 1 Nother (Specify) 28c. Injury at work? 28c. Injury at wor																
Divisi	- W - TO		3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	rmined 28e. Place of In	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory,	office		2	8f. Location (S City or Tow			or Rural	Route Number,	
	To the Hospi within 24 hou To the Funer completely fil	Medical	(Check 2 Li Medical	ng Physician: To the best o I Examiner: On the basis of ng Nurse Practitioner: To the	examination	and/or investig	gation, in m	ny opinion	, death occ	curred at t	he time, date ar	nd place	e, and due to	o the cau	se(s) and manner	stated.
	70 With		29b. Signature and title of dertifi		M, D		0		712			9.	ate signed (i	(		
			30. Name and address of person	who completed cause of a	death (Item	23a) (Type, Pr	int) X+	2	ito	4100	Bol	U.	1010	MI	31201	1
	Stat Registra	e r	30. Name and address of person TWWPSWW 31. Date filed (Month, Day, Year)	9 2011 32 Fiegistr	rar's Signatu	1. 40	Med		40	., 0.	-,	4.0.	(		- Clar	7

DHMH 17 Rev 06-2011

				se Type or Pri							•		_	ble.		
			1 - State Registrar		,				Death		•	Reg. No	2 0		28	767
	Physic	ian	1. Decedent's Name (First, Middle							2	Date of D	eath Day	y .	Year		of Death
	/Medi	cal	Annabelle Lou  4a. Facility Name (If not institutio		1		4h Cit	Town o	r Location of D	loath	04	07	County	of Death	5.	55 AM
4	Exami	П		uare Hos	spit	last birthda	R	ler 1 Year	CAAI	2	. Date of B	B	601	TIM	olace (Sta	te or Foreign
	Director		212-28-1419 Usual Residence of Decedent	1□M 2XF	80		Month	s Days	Hours N	Min.	Date of B (Month, D an • 2	23,19	31	Cour	sylva	
,	aryland show	_	10a. State 10b. County			ty, Town or I								1		City Limits
_	the Ma 28a-f	Director	Maryland Balti	more	Pe	rry H		Zip Code				10a Citi	izen of h	Vhat Cour		es 2 No
5	h with 23a or st be	al Di	8610 Jessica	Lane				128				U.S		Tigit Cour		
2 2 2	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	If Yes Give		.S. 13	3. Was Dec If Yes, sp 1 □ Yes		lispanic Origin an, Mexican, P Specify:	? (Speci uerto Ric	y Yes or N an, etc.)	0-	Blac	e - Americ *, White, c :: Whit	etc.	l,
7 - 6	"natu	letec	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dec	edent's Us	sual Occup vork done	eation during most of d)	working		16b. Ki	nd of Bu	ısiness/Ind	dustry	
7	l withir giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ce Ma					Cit	ti C	orp.		
Maryland 21215-0036	ild be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, James France I						18. Mother's Ruth				Surnam	ne)		
	nd 2 shou alth and N 27 is ma		19a. Informant's Name/Relations Donald E. Rice						and Number o Lane, Pe							
Baltimore	Pages 1 and tof Hermont; If item		20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation	3 □ Removal from State	20b. F	Place of Disp cemetery, cr	oosition (N ematory or	ame of other plac	ce)	Date	9	20c. Lo	cation -	City or To	wn, State	)
#i	t. Pertant		4 ☐ Donation 5 ☐ Other (S	pecify)	Arc				Inc. 9-					,Mary		
Ba	permi Depar Impor any ir		21. Signature of Funeral Service	Marcull-					ss of Facility rd Road							.A.
			23a. Part 1. Enter the disease, or	complications that caused	d the death								шут	andzi	Approxir	mate Between
d	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. A C U C  Due to (or as	Ct		oral	in	farc	til	n			0	Onset ar	Neek Neek
	Examiner	L	Sequentially list conditions	b												
^	rted	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Suie to (or as	g on sed	ue roe of):										
10	eath certificate be executed attending physician and for use as the burlal-transit	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):		_	<del></del>							
6876	ate be hysicia the bu	lical		d												
9 X	certific	/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	incv					-					
P.O. Box	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the certificate has been signed by the attending physici the Funeral Director: After this certificate has been signed by the attending physici apletely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1	2 Feta	I death 3	☐ Ectopic ☐ Other (		у			1	23d. Dat Mo	te of delive	ery Day	Year
	ding Physician: The law requires that the do.h. After this certificate has been signed by the funeral director, page 2 should be detached	by Ph	Part II. Other significant condition	ons contributing to death b	ut not resu	ulting in the	underlying	cause give	en in Part I.		23e. Did	tobacco u	ise conti	ribute to th	ne cause	of death?
Division of Vital Records.	require een sig tould b	ted t								_	1 🗆	Yes 2[	□No	3□ Prob	ably 4	Unknown
360	e law i has b je 2 sh	Completed						_		_	24a. Was	psy		prior to co	psy findin mpletion (	gs available of cause of
ta	in: Th ifficate or, pag		25. Was case referred to medical							D (	1 Yes	ormed? 2 No	1	death? 1 □ Yes	2□No	
Ž	ysicia is cert directe	To Be	examiner?  1 Yes 2 No	Haspital:	ent 2 🗆	ER/Outpatio	ent 3 🗆 [	OOA Oth	26. Place of er: 4 ☐ Nursir			,	 6 □ Oth	er (Specif	5v)	
ا ا	ng Ph (fter th Ineral	on: T	27. Manner of Death  1 Natural 5 □ Pendin	28a. Date of Inju	iry	28b. Time Injury	of	28c. Injur Work		$\overline{}$	l. Describe				<i>,,,</i>	
sio	ttendi death. stor: A	icati	2 Accident investig	ation	un. At be	uma farma a	M troot foote	1 🗆	Yes 2□No	200	1	<b>'0'</b>			-	
Div	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 ☐ Homicide determ	building, etc	c. (Specif)	y)						wn, State				iumber,
00	he Hosp n 24 hoi he Fune pletely fi	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examina	wledge, dea tion and/or	ath occurre investigation	ed at the tir on, in my o	ne, date and p pinion, death o	lace, an occurred	d due to the at the time	e cause(s) , date and	) and ma i place, a	anner as s and due to	stated. the caus	se(s)
Ψ_	Vithi To th	ž	29b. Signature and title of certifier		1. 2	_		9c. Licens					-	(Month,	-	
	- ^				MD			D + 0	605			sep	ten	ber	02,	2011
	20		30. Name and address of person  YUINGZHOO  31. Date filed (Month, Day, Year).	who completed cause of d	Fra	23a) (Type	Print)	qua	re Dr.	Ba	Itin	nore	M	D. 7	112	37
	Sta Registr		SEP 0 9 2011	Cerema 32. Hegistre	ar s sunar	N. S.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

201	2	8	7	6	8

		1- For State Registrar		Certific	cate of	Death		F	Reg. No.	11 20700
Physici Medical Exami		1. Decedent's Name (First, Mi Lee J.	3. Time of Death 2001 hrs							
		4a. Facility Name (if not institu 8706 Manahan Drive		mber)	4	b. City, Town, or Ellicott City	r Location of Deal		4c. County of Howard	
Funeral Director		5. Social Security Number 190–68–2381	6. Sex	7. Age (în yrs. last bi	rthday) Yrs.	If Under 1 Year Months Day		_	irth(MM/DD/YYYY) /82	Birthplace (State or Foreign PA
id how any tts.		Usual Residence of Decedent  10a. State 10b. Coun  MD	y Howard	10c. City, Tow		on ott Cit	У			10d. Inside City Limits 1 Yes 2 No
with the Maryland 18 23a or 28a-f sho e notified at once,	Director	10e. Street and Number 8706 Mana	han Drive	I		10f. Zip Code	21043		10g. Citizen of Wha	at Country? USA
after death al", or iten iner must b	by Funeral	11. Marital Status 1 Never Married 2 X 3 Widowed 4 1		2XX No	If Ye	Decedent of Hi s, specify Cuba Yes 2	spanic Origin? ( § n, Mexican, Puert o specify:	Specify Yes or N o Rican, etc.)	o- 14. Race - White, Specify:	American Indian, Black, etc. White
2 3 🗐	Completed t	15. Decedent's Education (S Elementary/Secondary (0-1 12	2) College (1-		during mo	st of working life	ation (Give kind of e. DO NOT use re ter Scie	tired)	16b. Kind of Bus	iness/Industry of Defense
the style	Be		teen					Bever.	Maiden Surname) Ly Rogal	
MD 21 d 2 should lith and Mer n 27 is man	ဍ		nship (Type, Print ) Ceen / W	ife	8706	Manahai	n Drive,	Ellico	mber, City or Town	ID 21043
Baltimore, MD 2121, permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		4 Donation 5 Other	on 3 X Removal fro	om State Wint	ergre	en Gorge	e Cemete	ry 9/1	10044	City or Town, State
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea										nc 21230 rt Approximate Interval
Medicat ≟xaminer		failure. List only one cau Immediate Cause (Final disea or condition resulting in death	se a. Hyperte	ensive Ath	erosc	lerotic	Cardiov	ascular	Disease	Between Onset and Death
	Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause.		ounsequence of):						
rted J ansit	Examiner	(Disease or injury that initiated events resulting in death) Las	C	consequence of):						
: 68760, certificate be executed anding physician and ise as the burial - transit	Medical	X UNPENDED	AMENDED 2	3a,27,per		919 9-2	3-11 sm			
certif	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 Live bit	ant at time of death	2 Feta	al death 3 er (Specify)	Ectopic pregn	ancy	23d. Date of d Month	leliv <b>ery</b> Day Year
P.O. es that the gned by the detache	2	Part II. Other significant cond	litions contributing to	death but not resulting	ng in the ur	derlying cause	given in Part I.			ute to the cause of death?  Probably 4 Unknown
of Vital Records, P.O. Box og Physician: The law requires that the death wher this certificate has been signed by the attender of the content director, page 2 should be detached for uneral director, page 3 should be detached for uneral director of the death d	24a. Was an autopsy performed?  1 Ves 2 No 1 Ves 2  25. Was case referred to medical examiner?									
Vital hysician this certi	To Be	examiner? 1 Yes 2 No	Hospital:		Outpatient	з 🔲 роа	Other Nursi		Residence 6	Other: Scene
ᆮ뜀글츠릭			28a. Date of (Month, prestigation	of Injury 28b. Day,Year)	Time of Inj		ry at Work? Yes 2 No	28d. Describe	how injury occurred	d
Division ospital or Attendi hours after death.	Certification:	3 Suicide 6 Co		of Injury - At home,	farm, street	, factory, office b	ouilding, etc.	28f. Location ( or Town,		r or Rural Route Number, City
Division  To the Hospital or Attenwithin 24 hours after death To the Fuoeral Director:	edical	one) 2 Medical E	Physician: To the best caminer: On the basis of and manner sta	f examination and/or		on, in my opinior	n, death occurred		and place, and du	e to the cause(s)
	Ž	29b. Signature and title of cert	fier			29c. Licens O.C.			August 27, 2	d (Month, Day, Year) 2011
OCME		30. Name and address of pers Mary G. Ripple MD				W. Baltimore	e Street, Balti	more, MD 2	1223	
St Regist	ate rar	31. Date filed (Month, Car, Ca	0 9 201 32 Rec	gis ar's Signature	1. 4	and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month September 9, Year 2011 7:10 AM Josephine Catherine Spivey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper House Forest Hill Harford If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Year) 90 Days Hours 213-18-7159 Maryland **Director** 1921 1 □ M 2 X F Usual Residence of Decede 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 Yes 2 X No 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 310 Sassafras Road 21221 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Inforbant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent Ever in U.S Armed Forces? 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 **X** No þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Ferrare Mary Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Spivey-Ireland /Daughter 1807 Plainvue Way Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sep 10 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licens Name and Address of Facility
Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): l or Attending Physician: The law requires that the death certificate be executed after death. burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the as the attending IF FEMALE use a 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery for in the past 12 months? Pregnant at time of death Month 1 Yes 2 No 9 Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 24 hours after death. Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D 29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Centifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o 29b. Signat are and title of ce 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Kidt

Koos

30. Name and address of person who completed cause of death (item 23a) (Type, Print

31. Date filed (Month: Bay Year

(AMOUD)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EUGENE LEE SCHUYLER SEPTEMBER 2011 2:40 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, Year) 217-24-9133 Director 1 🛛 M 2 🗆 F 83 Usual Residence of Decedent MARYLAND 8/3/1928 show at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD BALTIMORE 1 Yes 2 XNo PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1753 WESTON AVENUE USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced 19487 WHITE Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the POSTAL SERVICE YEARS INDUSTRIAL ENGINEER other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hymportant: If item 27 is mornany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EDWARD SCHUYLER ELLA NORA CHRISTIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARA SCHUYLER/WIFE 1753 WESTON AVENUE BALTIMORE. MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY. 9/8/2011 INC! CATONSVILLE. 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau ie on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) sequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be Box 68760 the as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death Day Year 2 No 9 Unknown Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed No ours after death.

eral Director: After this certificate hilled in by the funeral director, page 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1.ANatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 5811500C Name and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When and address of person who completed cause of death (Item 23a) (Type Print)
When a complete the complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 23a) (Type Print)
When a complete cause of death (Item 25a) (Type Print)
When a complete cause of death (Item 25a) (Type Print)
When a complete cause of death (Item 25a) (Type Print)
When a complete cause of death (Item 25a) (Type

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 6:32 2011 Sept Dorothy Rose STull Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 G Days Months Hours Min Month, Day, Jan 16 Country) Maryland 214-26-3559 Yrs 1931 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10c. City, Town or Location must be notified at Director Glen Burnie 1 ☐ Yes 2 🗓 No MD Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7854 Twin Ridge Drive USA 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status if Health and Mental Hygiene.
item 27 is marked other than "natural", or iten
other traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ tho Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Administrative 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Marguarite Hartlove should be Earl Clemens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Columbia, MD 21044 5057 Rushlight Path Michele Toth (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important; If ite any injury or ot once. cemetery, crematory or other place) 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadworidge Memorial Park 9/12/2011 Elkridge, MD <sup>22.</sup> Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, Inc.
7250 Washington Blvd Elkridge, Maryland 21075 of Funeral Service Licensee Signatur Approximate Interval Between Onset and Death 23a. Part 1. Enter he disease, or complications to shock, or near failure. List only one cause used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Metastatic Breast CANCER Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year Day signed by the at d be detached for 9 Unknown To the Hospital or Attending Physician: The law requires that the P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in by 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, MARYLAND

Registrar DHMH 17 Rev 7/2009

State

KATHRYN 31. Date filed Month, Day, Year CEDAR LANE

6336

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Smith 2011 Larry Sept 20:27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Univ. of Maryland Medical Ctr Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min (Month, Day, Ye York, PA 75 185-28-0801 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a, State 10c. City, Town or Location Director PA York Dover 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Cardinal Lane 17315 Funeral 3301 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc ö ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Manufacturing Shipping Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever Harold F. Smith မ Kathryn A. Myers 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2034 W. Philadelphia Street York, PA 17404 Corrine L. Brenner (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 10, Susquenerna Memorial
Carcers 1 Burial 2 Cremation 3 Removal from State York, PA 17402 4 ☐ Donation 5 ☐ Other (Specify) Signature of Faperal Service Licer Name and Address of Facility Evans Funeral Chapel & Chemation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition <u>Cardiac Arrhythmia</u> Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Exam Due to (or as a consequence of): physician Physician/Medical Box 68760 the 38 ves, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🌠 No 24a. Was an autopsy has certificate Yes 2X N filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 27. Manner of Death s after death. 28d. Describe how injury occurred injury **X**Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation in my reliable to the cause and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 7, 2011 Sept. 101980 eon who completed cause of death (Item 23a) (Type, Print) 30. Name and address D.O. 22 S. Greene St., Baltimore, Md 21201 Lunny, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

SEP U y 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner fution, give street and number City, Town, or Location of Death 4c. County of Death mo 21 Bout mwe. 6. Sex **Funeral** ge (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 T Months Hours Min (Month, Day, Yea 7/04/19 **Director** 74 MARY MAND 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE MD Yes 2 □ No ò 10e Street and Number must be 10g. Citizen of What Country? Funeral 23a A15 OUI U.S.A. 21218 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items ant If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ 1 Yes 2 No Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Post OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ٩ Naaman BROWN SIMMONS 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Imber or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 23 any injury or other t HUSBAND BALTIMORE, MARYIANA ethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 13 12011 Signature of Funeral Service Licens 22. Name and Address of FaciliTAE DERRICK C. JONES FIH, AA AUE. BALTIMORE, Md, 21215 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 751 disease or condition Medical resulting in death) Examiner hou Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events to for as a consequence on burial-transit and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) õ Pregnant at time of death Month the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribcte to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performe certificate Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 မြ 1 Inpatient 2 4 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation M 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who cor e of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Registrar's Signature

9 2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sponaugle Tamara Lee Physician/ 7:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN ROSEDALE BALTIMORE HOSPITAL QUARE If Under 1 Year If Under 24 Hrs. Birthplac Country) MD 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 220-62-1246 7. Age (In yrs. **58 Funeral** Days Hours Min (Month, Day, Year) 09/05/1953 1 M 2 X Director Fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Baltimore 28a-f 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? ò 1123 Old Eastern Avenue, Apt.A 21221 USÁ Funeral 23a items ? 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ō ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 12 should e filed within 72 alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant 10 SPONAULLE traumati event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph F. Koslosky Iris Kreuzer ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health ar Important: If item 27 is any injury or other trau 4803 Sennett Ct., Nottingham, MD 21236 Shane Sponaugle/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/8/2011 Glen Burnei, MD 22. Name and Address of Facility Cremation Services 21. Signature of Funeral Service Licensed Dorota Marshall PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIOPULMONARU disease or condition Medical resulting in death) Examiner RESPIRATORY COMPROMISE SECONDARY TO LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No Other: ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO Me Cly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237 DR. MOHAMAD CHEHAB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0325 amp eptember 6, 2011 Medical me (if not institution, give street and number) Examiner 4c. County of Peath 405 rmore NIA 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 1 M 2 D F Months (Month, Day, 212-28-6805 Hours Min. Director pt Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 28a-f MT altimor 1 Tes 2 No ö 10e Street and Number 10f. Zip Code ms 23a or must be Funeral I 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with 21207 USA items? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. ò ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Specify: Slack Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the M than Elementary/Seconday (0-12) College (1-4 or 5+) river Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ernell amp Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. aa 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 2011 of Funeral Service Lice 22. Name and Address of Facility Howell Ave, Balto MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Ph\_sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events monic Renal fanher Exami -tran and Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Yes 2 No 9 Unknown Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nocavanoma 1 ☐ Yes 2 Loo 3 ☐ Probably 4 ☐ Unknown page 2 should Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 100 Other: |은 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending Accident
Suicide Investigation М 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Leted cause of death (Item 23a) (Type, Print) Name and address of person who com State Registrar

OHMH 17 Rev 7/2009

11-06676 Alice J. Sona Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

viice J. Song		1- For State	e of Maryland / De )	epartment of C <i>ertificate o</i>		id Mental H		201	1 28778
Physici		Registrar  1. Decedent's Name (First, Middle, L	ast)				Date of Dear     Month	Day Year	3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution,	Song		4b. City. Town. or	r Location of Deat	Septembe	er 4, 2011 4c. County of Death	1424 hrs
		5966 Turnabout Lane	,		Columbia			Howard	
Funeral Director		5. Social Security Number 6. <b>220–86–4740</b>	/	rs. last birthday)	If Under 1 Year Months Day		7 (	th(MM/DD/YYYY) 9. Bir Foreig	gn , , , ,
		Usual Residence of Decedent	M 2 F	43 Yrs	6.		teb o	23, 1968 0	untry) Koreau
w any		10a. State 10b. County	,	City, Town or Locat	1				10d. Inside City Limits
te Maryland or 28a-f show fied at once.	Director	10e. Street and Number	Nard	Colu	10f. Zip Code	_	<u> </u>	0g. Citizen of What Cou	
ı with the Maryland ms 23a or 28a-f sho he notified at once.		5966 Tur	nabout L	ane		044		USQ	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must he notified at once	Funeral	11. Marital Status 1 Never Married 2 Marr.	12. Was Decedent Ever ed Armed Forces?	lf Y		ispanic Origin? ( S n, Mexican, Puerte		14. Race - Amer White, etc.	ican Indian, 8lack,
after de ti", or i	by Fu		1 Yes 2 Need If Yes, Give Yeer or Dates:	1	Yes 2 No	specify:		Specify: A	Sian
hours natura	ted b	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade complete College (1-4 or 5+)	d) 16a. Deceder during m		ation (Give kind of e. DO NOT use re		16b. Kind of Business/	Industry
15-0036 filed within 72 Hygiene. ed other than "t the Medical	Completed	12	College (144 of 5+)		Clerk			Libra	rup
21215-0036 uld be filed within 72 hours afte Mental Hygione. marked other than "natural", c event, the Medical Examiner	Be Co	17. Father's Name (First, Middle, La	st) 0009			18.Mother's Nam	e (First, Middle, I	Maiden Surname)	0
AD 2121 (2 should be fill and Mental F 27 is marked matic event, 1)	To B	19a, Informant's Name/Relationship		19b. Mailing	g Address (Stre	et and Number or		nber, City or Town, State	, Zip Code)
ME and 2 s and 27 a		YoN Sheen 20a. Method of Disposition	Song	Ob. Place of Dispos	<u> </u>	erton	Kd, E	20c Location - City or	Fy, MD
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 nijury or other traun		1 Burial 2 Cremation	3 Removal from State	crematory or other		Land al	1212	1 1	
Baltimo permit. Page Department of Important: injury or oth		Donation 5 Other Special Other Other Special Other Other Special Other Other Other Other Special Other Ot	S /	. 970.	Name and Addres	is of Facility	812011 2 WIE ( 0	Hanove	
ம் உட்பிய Physician		23a. Part I. Enter the disease, or co	mplications that caused the de	eath Do not enter t	220 (5)	ultoro	RCI,	Jessup,	Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease							Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequen-			J		WI 10D	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequen-	ce of):					
_ #	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent	ce of):					
60, ate be executed hysician and te burial - transit	Cal	X UNPENDED	d. X AMENDED <b>23a, pt</b>	.TT-27-28	8a-f per	те с924	2-2-12	vt	
' <b>60,</b> ate be e		IF FEMALE:	AMENDED 23a, pt 5perFH 23c. If yes, outcome of p		2011,WS	ше 6724	2 2 12	23d. Date of deliver	<u> </u>
Box 6876 e death certifical the attending phed for use as the	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	2 Fe	tal death 3	Ectopic pregn	ancy	Month I	Day Year
BO)	Physician/	1 Yes 2 No 9 V Unkno	O GINGIOWII						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Š	Part II. Other significant condition Diabetes Mel		not resulting in the u	underlying cause	given in Part I.		obacco use contribute to	
of Vital Records, ng Physician: The law requir ther this certificate has been si nneral director, page 2 should t	ompleted						24a. Was		utopsy findings available completion of cause of
Reco The law icate has	mo;							rmed? death?	
ital Redician: The scentificate rector, page	Be	25. Was case referred to medical examiner?	Hospital:			e of Death (Check			
ing Physi After this funeral dir	1: 10	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yaar)	ER/Outpatient		ury at Work?		Residence 6 🗹 Othe	r: Scene
Division tal or Attendi rs after death.  at Director: A led in by the fu	atio	fell							
Division of the state of the st	Certification	3 Suicide 6 Could n 4 Homicide determi			et, factory, office I	building, etc.	or Town, S	Street and Number or Ru State) <b>5966 Tur</b> <b>ia, Md.</b>	ral Route Number, City rabout Lane
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Phys	Ician: To the best of my know	vledge, death occur			d due to the caus	se(s) and manner as stat	
To th within To th comp	Medical	one) 2 Medical Examile 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	on and/or investigat	29c. Licens		at the time, date	and place, and due to the 29d. Date signed (Mo	
		0-~	-		O.C.			September 5, 20	
de de		30. Name and address of person who		•	\\\ Da\\\:	Chrost Dell'	110.01	222	
S	ate	Donna M. Vincenti, MD  31. Date filed (Month, ay, Year)	Assistant Medical E			e Street, Baltii	more, MD 21	223	
Regist		CED (192	177 Menus	natur Bar	Re				

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		artment of H		and M		_ Z [] [		28777
			Registrar  1. Decedent's Name (First, Middle, Last)		incate or D	Catri		2. Date of Deat	leg. No.		3. Time of Death
	Physicia		Norma Angela Seifert					Septemb	er 5,201		5:45A. M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of		<u> </u>	4c. County of		
			Oak Crest Care Center			Park	ville	е		Balt	.0.
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 XF 90	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, July 2			ce (State or Foreign
	7 A		Usual Residence of Decedent								
	ırylan a-f sh ied a	Director	Md. Balto.	Town or Lo	Parkvil	le				10d	I. Inside City Limits  1 ☐ Yes 2 👿 No
	or 28¢	Dire	10e. Street and Number		10f. Zip Code				10g. Citizen of Wh	at Country	
	with t	Funeral	8820 Walther Blvd. Unit 2204			1234			US		
	leath items er mi	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Orig	gin? (Spec	ify Yes or No-	14. Race -		
36	after o I", or xamin	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		☐ Yes 2 🛣 No			ilcari, e.c.,	Black, Specify:	White, etc	White
9	nours natura ical E	Completed	3 XWidowed 4 □ Divorced If 1es, Give Year or Dates.  15. Decedent's Education	16a. Deced	ent's Usual Occupa	ation			16b. Kind of Busi	nace Indus	stry
215	n 72 h e. Ian "r Med	dmo	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give F	kind of work done do O NOT use retired)		of workin	g	TOD. KING OF Edail	ness made	sti y
7	l withi ygiene her th t, the		12th		Homer	maker	<u> </u>			Нс	ome
Maryland 21215-0036	e filec ntal H ed ot	To Be	17. Father's Name (First, Middle, Last)						Maiden Surname)		
<u> </u>	ould bid Meid Meid Meid Meid Meid Meidel Mei	ľ	William S. White  19a. Informant's Name/Relationship (Type, Print)	10h Mailin	g Address (Street a			Lorber	Oit on Town State	4- 7i- 0	4-1
Z Z	d 2 sh alth an a27 is er trau		Wayne D, Seifert Son		21 Overl						ie)
ore,	of Her of Her fiter				sition (Name of natory or other place	9)	D	ate	20c. Location - C	ity or Town	n, State
<u>Ë</u>	. Page ment tant: I			boows	Cemetery	9	-10-		Parkvill		1.
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if field and Mental Higher 1 important if field 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	73	21. Signature of Funeral Service Licensee	22	Name and Address		4 173717		uneral H ngham, M		1236
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
∴ F	hysician/	1 19	Immediate Cause (Final disease or condition								nterval Between Inset and Death
أرسا	Medical Examiner		resulting in death)  Due to (or as a consequent								
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequer	nce of):						-	
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or impory that initiated events  c.	,						30	
	death certificate be executed the attending physician and ed for use as the burial-transit.	EX	resulting in death) Last  Due to (or as a consequent	nce of):							
09	ate be ohysic the bu	dical	d							+	
687	sath certifica attending pl for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnanc	v					20d Date	-6 d - live	
Вох	eath c atten I for u	Physician/Me	in the past 12 months?  1 Live Birth 2 Fetal of the past 12 months?  1 Ves 2 No 4 Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)	/			23d. Date of Month		
о О	the de by the ached	hysi	9 Unknown					1	<u> </u>		
<u>.</u>	I he law requires that the de, ate has been signed by the a page 2 should be detached	þ	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause give	en in Part I	l.		pacco use contribu		
rds	equire een si nould l	eted	COPD		<u>-</u>			1	es 2 No 3		
Vital Records,	S 00 01	Completed						24a. Was au autops perforr	sy prio	ere autopsy or to comp ath?	findings available findings available of
ğ i	sician: The la certificate ha irector, page 2		25. Was case referred to medical		0C DI-	f Dt	t- (0+ t	1 Yes		Yes 2	140
Vita :	iysician: iis certific director,	To Be	examiner? 1	R/Outpatien	Other	ce of Deat		,	unas 6 🗆 Othar (	(Chapiful	
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of injury  28.											
O D D D D D D D D D D D D D D D D D D D											
Division of	ipital of Attendous after deat eral Director: filled in by the	Certificate:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		2	8f. Location (Sta City or Town	reet and Number o , State)	or Rural Ro	oute Number,
	no the Hospital within 24 hours a To the Funeral t completed filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled								
	vithin 24 h	Mec	(Check 2   Medical Examiner: On the basis of examination at only one) 3   Certifying Nurse Practioner: To the best of my ki		eath occurred at the	time, date					
	Nitl Con		29b. Signature and title of certifier	A	29c. License		2	2	9d. Date signed (A	Month, Day	y, Year)
			acce this organit		RO67	37:	2		week.	4,2	0//
e			30. Name and address of person who completed cause of death (Item 23		Ther Bl	IN	Pan	basion	sept.	. a).	12.34
	Stat	E	31. Date filed (Month, Dav. Year)	A		K	- 000	- UMCC	x / va O		
	Registra	ir	SEP 0 9 2011 Burns B. Sax								

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

**Division of Vital** 

		Please 7	Type or Pri						-		_	ble.	
	-	For State Registrar	State of Ma	aryiar			te of £		wentai F	iygien Reg. N	001		28779
Physicia		1. Decedent's Name (First, Middle, Last)  Mildred & Tysor	\						2. Date of Month			Year	3. Time of Death
Medic Examine		4a. Facility Name (if not institution, give st	reet and number)					r Location of Deat			c. County o	_ , ,	
Funeral		5. Social Security Number 6. Sex			ast birthday)		er 1 Year	If Under 24 Hrs Hours Min.		Birth Day, Year)		9. Birth	olace (State or Foreign
Director	_ h	Usual Residence of Decedent		64	Yrs.				6/2	8/47			MD
Maryland 28a-f sho atified at	rector	10a. State 10b. County I	N/A	10c. Cit	y, Town or Loc		Balti	more					10d. Inside City Limits 1 1 Yes 2 ☐ No
with the 23a or 2	Funeral Director	10e. Street and Number 119 W. Randall	Street			10f. Z	ip Code	21230	· ·	10g. (	Citizen of WI	nat Cour US	
ter o	۾	11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1  Yes 2XX If Yes, Give Year or Dates.		If	Yes, spe	ecify Cuba	ispanic Orlgin? (S In, Mexican, Puerl Specify:	pecify Yes or Note Rican, etc.)	lo-		- Americ , White,	ean Indian, etc. White
vithin 72 hour iene. r than "natu the Medical	Completed	15. Decedent's Ed. (Specify only highest grad		+)	16a. Decede (Give ki life. DC	ind of w NOT u	ual Occup ork done o se retired) <b>emake</b>	during most of wo	rking	16b.	Kind of Bus	iness In	
be filed w ental Hyg ked othe c event,	To Be	17. Father's Name (First, Middle, Last)  Joseph O'Dono	van					18. Mother's Na	me (First, Midd abeth	fle, Maide	n Surname) Englen	nan	· .
d 2 should aith and Me 27 is marl ar traumati		19a. Informant's Name/Relationship (Typ Raymond A. Tys	e, Print) / Hus	band	19b Mailing	a Addres	ss (Street anda I	and Number or Ri LI Street	ural Route Nun Balt	nber, City o	or Town, Ste	21 23	Code)
Page 1 and of He and of He and: If item		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	20b. F	Place of Dispos cemetery crem ar Hill	atory or	ame of other place Meter	ÿ 9/	Date 14/2011		Location - C	-	own, State aryland
permit. Departr Imports any inju	ĺ	21. Signature of Funeral Service Licenser	Victor P.	Dod	a,Jr.22	Name a	es L.	ss of Facility Stevens ort Aveni	s Funer	al Ho	ome, ]	[nc.	30
Physician/ Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line	car	h. Do <i>n</i> ot enter	r the mo					e MD		Approximate Interval Between Onset and Death
Examiner	<u>.</u>	Sequentially list conditions.			,								unknown
i a e	cal Examiner												
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE:	3c. If yes, outcome of 1 ☐ Live Birth 1	2 🗌 Feta	al death 3 🗌	Ectopic Other (s		· Sy		-	23d. Date Mon		ery Day Year
res that the signed by the detaction	à	Part II. Other significant conditions con	tributing to death bu	ut not res	sulting in the ur	nderlying	cause giv	ven in Part I.					he cause of death?
The law requi	Completed								24a. W	as an itopsy erformed?	24b. W	ere auto ior to co eath?	psy findings available impletion of cause of 2 \square No
sician: certifica irector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	0 D	ER/Outpatient		Othe	ace of Death (Che	eck only one)				
iding Phy th. : After this : funeral d	cate; To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injur (Month, Day,	у	28b. Time of injury	M	28c. Injury work	y at	Home 5 Re 28d. Describ				0
tal or Atter rs after dea al Director ed in by the	al Certificate;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc.			et, facto				n (Street a Town, Stat		or Rura	l Route Number,
ne Hospi n 24 hou te Funer: pleted fill.	Medical	29a. Certifier (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of ex	aminatio	n and/or investi	gation, ir	n my opinia	on, death occurred	at the time, da	te and plac	e, and due t	to the ca	use(s) and manner state
To th within To th		29b. Signature and title of certifier  Vlug	MMD				ic. License	number			ate signed		
		30. Name and address of person who con					Balt	timore,	MD 21	202			
State Registra		31. Date filed (Month, Day, Tear) SEP 0 9 20										-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEP7 12-28 PM TODMAN OURTNE! 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genera Columbia Howard iountu Howar Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Days USUPPREINIS **Director** 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director Yes 2 No 5 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No I Yes, Give Year or Dates. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City of Town, State cemetery, crematory or other place) 21. Signature Funeral Service Licenses 23a. Part 1. Energine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STA GE RENAL DIS END disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ABETE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence on). Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by valvulas hee Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Yes To Be ( 26. Place of Death (Check only one) examiner? Other: 2. JM0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

DHMH 17 Rev 7/2009

State

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07

entico la Sute

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State	of Mar	yland / De C	partme e <i>rtifica</i>	nt of F te of E	lealth a Death	and M	1ental Hy	giene Reg. No.		28781
Physicia Medic		1. Decedent's Name (First, Midd Bolivia Carden	,	ms						2. Date of De Septem		3, 2ďľ	3. Time of Death 3:30 am
Examin		4a. Facility Name (if not institution Rebecca House	on, give street and nu	mber)		4b. Cit Po	y, Town, or tomac	Location o	of Death			County of Dea	
Funeral Director		5. Social Security Number 578–50–3796	6. Sex	7. Age (Ir.	yrs. last birthda	Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 9/22/1	ıy, Year)	C	irthplace (State or Foreign ountry) Ecuador
ryland I-f show ied at	Director	Usual Residence of Decedent  10a. State 10b. Count  MD Mont	gomery		oc. City, Town or Bethesda								10d. Inside City Limits 1 ☐ Yes 2 ▼ No
vith the Ma 23a or 28¢ st be notif		10e. Street and Number 6110 Bradley	_ †_			10f. Z	ip Code 817				10g. Citi	izen of What C	**
laryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Voc C	orces? 2 <b>½</b> No ve	in U.S. 1	If Yes, sp	edent of Hi ecify Cuba 2 🗌 No	n, Mexican	gin? (Spe Puerto I Ecua	cify Yes or No- Bican, etc.) doran		14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Examone.	Completed	15. Deced	ent's Education hest grade completed		(Gi	cedent's Us ve kind of w DO NOT u	ork done d se retired)	luring most	t of worki	ng		nd of Business	
rland 2 I be filed wi fental Hygie rked other tic event, t	To Be (	17. Father's Name (First, Middle, Caton Cardenas	Last)						er's Name fina	e (First, Middle, Monje	Maiden S	Surname)	
ore, Marylar and 2 should be of Health and Mente fitem 27 is marker rother traumatic e		19a. Informant's Name/Relation Marcos S. Will	ship (Type, Print) iams, son							l Route Numbe hesda,			ip Code)
Baltimore permit. Page 1 ar Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Burial 2X Crematio 4 ☐ Donation 5 ☐ Other		n State	20b. Place of Dicemetery, of Chesape	rematory or ake Cr	other plac cemato	ory 9	/8/2	011	Be1	cation - City o	e, MD
Ball permit Depart Impor any in		21. Signature o Funera Jergio			MO1539	22. Name a	and Addres	s of Facilit	y Rap ilve	p Funer r Sprin	al &	D 2091	tion Svcs.
∽ Physician/ Medical		23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	ach line. heime	r's dem		de of dying	9, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death 8 years
Examiner	er	Sequentially list conditions.	b		onsequence of):								
ate be executed bhysician and the burial-transit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	С		onsequence of):		*						
ate be e	edical		d										
ords, P.O. box 68/ requires that the death certific been signed by the attending I should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown		Birth 2 D	Fetal death	B Ctopic		у			2	23d. Date of d Month	elivery Day Year
dS, P.O. quires that the en signed by tould be detach	by	Part II. Other significant condit	ions contributing to	death but n	not resulting in th	e underlying	g cause giv	en in Part I	l.				o the cause of death?  Probably 4 🗆 Unknown
HeC The law cate has	Completed									1 Tyes	psy ormed?	prior to death?	utopsy findings available completion of cause of es 2  No
VITAI hysician his certifi Il directo	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2★★No	Hospital:	Inpatient	2 🗌 ER/Outpa	tient 3 🗌 [	Othe	ace of Deat er: 4 🔀 Nu		only one) me 5 Resid	dence 6	Other (Spe	cify)
On OT ending P eath. or: After ti he funera	Certificate:		tigation	of injury oth, Day, Ye	ear) 28b. Time injur		28c. Injury work' 1 🗌	at ? Yes 2 🗌		28d. Describe h	now injury	occurred	
DIVISI tal or Atture after de al Directo led in by t		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 28e. Place	e of Injury - ing, etc. (S	At home, farm, pecify)	street, facto	ry, office			28f. Location (S City or Tox			ural Route Number,
the Hospi nin 24 hou the Funer	Medical	(Check 2 ☐ Medical only one) 3 ☐ Certifyir	g Nurse Practitione	sis of exam	ination and/or in	estigation, ir ge, death oc	n my opinio curred at th	n, death oc ne time, dat	curred at	the time, date a	and place,	and due to the	cause(s) and manner stated.
To with		29b. Signature and title of certification with the control of the certification of the certif		term	un, M.	D. 29	D5245				29d. Date 9/7	e signed (Moni /2011	th, Day, Year)
10		30. Name and address of persor Michael A. Wes					ional	Mil:	itary	y Med.	Ctr.	Bethes	sda, MD
Stat Registra	•	31. Date filed (Month, Day, Year) SEP 0 9 20	11 Janes	Registrar's	Signature far	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WH Medical 4a. Facility Name (if not institution, give street and number)
Season's Hospice 4b. City, Town, or Location of Death 4c. County of **Examiner** Baltimore Randallstown 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under **Funeral** Days Hours (Month, Day, Year) 03/12/1935 212-30-9991 76 **Director** 1 □ M 2 **X** F Yrs 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Parksley Avenue 21223 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural" Completed 3XXVidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 8 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, if Health and Mental I item 27 is marked o Hiltner Mildred Howard ည Hanson Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bryna Whitaker/Son 4302 Fordham Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake crematory 20a, Method of Disposition 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot 1 
Burial 2 
Cremation 3 
Removal from State Greenbelt, MD 9/9/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD Lear Shall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on ach line Interval Between Immediate Cause (Final Onset and Death Phytician/ DP 4 MONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause (Disease or injury Due to for as a consequence of as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by 1 d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed completely filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate Yes 2 25. Was case referred to dica examiner? 26. Place of Death (Check only one) Be Other: မ 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury V Natural within 24 hours after death. To the Funeral Director: Ai Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide deter mined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year, SEP 0 9 20

2011

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monti Madeleine Theresa Wolfkill 425 PM otembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lursina ire . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1<u>928</u> Country Maryland 1 □ M 2 😾 F Davs Hours Min Feb. 24. 218-26-4847 83 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 X No PA York York 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 1308 Whiteford Road 17402 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supply Clerk U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emil (nmn) Lengrand Theresa (nmn) Darchicourt of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Wolfkill / Son 1308 Whiteford Road, York, Pennsylvania 17402 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of h Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9/12/2011 Towson, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Marker Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, in each line. Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the burial Completed by Physician/Medical Madeleine Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 4 Pregnant 9 Unknown 1 Li Yes 2 L 9 I Unknown vate nas been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate l 1 ☐ Yes 2 ☐ No Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Ves 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manna of Death of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Division work? Accident 2 No Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) the 29b. Signature and title of certifie License number 29d. Date signed (Month, Day, Year) 30. Name and ith, Day, Year) State 0 9 2011 Registrar

DHMH 17 Rev 7/2009

WOIFKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 21,22 per fh g919 9-9-11 vt 25 per verb State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August Albert Joseph Wolfe 26. 2011 11:30A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City 5033 E. Preston Street Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Hours February 7º 1925 Hagerstown, Maryland 86 **Director** 219 14 9230 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City Baltimore City 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5033 E Preston Street 21205 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Newspaper Delivery Newscaper Delivery Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Unknown William Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Crafton Road Mary Ash (Daughter) Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. August 30 2011 Baltimore, Maryland 22. Nar Hove libss Funeral Home 3331 Brehms Lane nature of Fune Broizage / Howell Sr 21213 7401 Pelair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Disease of unlenown Physician/ one mouth disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence on). Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ Chronic Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu August 26,2011 D0032548 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
PEVY COLVIN MD TALLE LLICE Hopkins Bayview Medical Center, Baltimore MD Johns State Registrar **PHMH 17 Rev 7/2009** 

カエ

S

20

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Randy Lee Waltz August Рм 2011 2:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Dec. 9, 1**⊠** M 2 □ F Hours 216-54-7877 60 Maryland Director Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Frederick Frederick 10e, Street and Number 10f. Zip Code 9 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 8052 Ball Road 21704 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. 1 Never Married 2 X Married δ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Contracting Mechanical Contractor Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Glen Waltz Dawn Houff traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8052 Ball Rd., Frederick, MD 21704 Rita Waltz / Wife other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Sept<sup>Date</sup> 1, 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 21. Signature of Funeral Service Restmaded Funeral Services, Skkot Cody P.A. Frederick, MD 21701 M01237 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, shock, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one caus, on each line. Immediate Cause (Final Onset and Death Pnysician, trobable Hepatocellular carcinom disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): -transit and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Por in the past 12 months? Pregnant at time of death Unknown 2 No ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, DINBYTES 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Depatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury
28c. this eral Director: After thi filled in by the funeral 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, dea ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar Thomas

Frederick MD 21702

Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah

31. Date filed (Month, Day, Year)

5

3altimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 1 Yes 2 No 3 Probably 4 Unknown completed filled in by Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 17418 2011 2/20/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sava M. Handley 22 S. GREENE ST. BALTIMORE 31. Date filed (Mont State 09 Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #1 Per PHY G919 9/20/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Month Day 35 AM 4 **Physician** September 4c. County of Death PANIEL ZINCK 4 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center Raltimore 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) May 24, 1985 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**√** M 2 □ F 26 Yrs. Director <u> 220-08-0936</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 √ Yes 2 □ No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number **USA** 21222 2017 Bear Ridge Road Apt 103 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: White 1 ☐ Yes 2 📈No Baltimore, Maryland 21215-0036 Š 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jaqueline Wathen William Gary Zinck Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2017 Bear Ridge Road Apt 103 Baltimore MD 21222 Jaqueline Abbas-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sep.9,2011 Glen Burnie Maryland Glen Haven Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory hour **Physician** /Medical Due to ( r es a consequence of) **Examiner** Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 - Ectopic pregnancy Live birth Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 2 🗌 No Ýes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Hospital: 5 Residence 6 Other (Specify) 12 Inpatient 3 DOA 2 ER/Outpatient 1 ☐ Yes 2 Z No ၉ eral Director; After this filled in by the funeral di 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Registrar

DHMH 17 Rev 1/2001

ranagis

31. Date filed (Month, Day, Year)

back

32 Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GALIATSA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 2011 Mary Annette Altvater August 2:15 PM Medical Examiner 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 😿 F Hours **Director** 219-18-7457 Mary land 86 Yrs. Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🖺 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11648 Gum Point Road U.S.A. 21811 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 Never Married 2 Married ₫ Baltimore, Maryland 21215-0036 ☐ Yes 2 😾 No 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edison Zink Nettie Bensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine L. James (Daughter) 11648 Gum Point Road Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Pk. 8-31-2011 Elkridge, Maryland 21. Signature of uneral Service Licer 22. Name and Address of Facility Witzke Funeral Homes, 0 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or co shock, or heart failure. List only emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine dye to (or as a consequence of): the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy e Hospital or Attending Physician: The I 24 hours after death, • Funeral Director; After this certificate h performed? Yes 2 XNo After this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: မ 1 Yes 2X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R 135131 August 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP 9715 Healthway Dr., Berlin, MD 31. Date filed (Month, Day, Year) **SEP 1 2 201**7

Registrar DHMH 17 Rev 7/2009

State

Mary

Altvater,

§2. Registrar's Signature

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible. amend Item 19a per the grid 9-20-I Five State of Maryland / Department of Health and Mental Hygiene For State Registrar 28789 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death  $^{\text{Day}} 2\underline{011}$ Physician/ Month 9 Year Bonnie Andersen 9  $P^{\mathsf{M}}$ Jean 6:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Anne Arundel 601 Elizabeth Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Age (In vrs. last birthday) (Month, Day, Year) 08/31/1936 Days Hours Min 1 □ M 2 😾 F 75 Chicago, IL **Director** 356-28-2327 Usual Residence of Decedent 28a-f shov 10a, State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗆 Yes 2 😾 No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 Elizabeth Road 21061 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced SpecifyWhite Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Franklin William Hult Laverne Hansen 19a. Informant's Name/Relationship (Type, Print)
Andersen
Robert G. Anderson/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 Elizabeth Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State Crownsville, MD Crownsville Md Vets 9/16/2011 4 ☐ ponation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Furreral Service Licensee Kirkley-Ruddick Funeral Home Glen BUrnie, MD 210d1 Me 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) (1900 NS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consecuence of cause. Enter Underlying Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter in the past 12 months? Pregnant at time of death Month Dav Year ı signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 24 certificate 2 (No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Tyes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pyactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h Signature and title of certifier Date signed (Month, Day, Year) tembe 10 8h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Date filed (Month, Day, Year 32. Registrar's Signature State Registrar acks

			For State		State o	f Marylan		artment of I		and Mer	ntal Hygi	ene		00700
_			Registrar  1. Decedent's Name (		1004)		Cer	tificate of	Death	1.0		g. No.		28/90
Ph	ysicia	n/		_	,						Date of Death Month	Day 29	Year	3. Time of Death  2 49 PM
A 1	Medic xamin		David Ar 4a. Facility Name (if no		ive street and num	ber)		4b. City, Town, c	or Location o		Just _	T	Z0]] ty of Death	10.77
	neral ector		5. Social Security Nun 220-42-(	)619	. Sex 1 ፟፟ M 2 ☐ F	7. Age (In yrs. Ia 66	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth	1944	9. Birth Coun	place (State or Foreign stry)dTTK
p	d at	Ē	Usual Residence of D 10a. State	ecedent 0b. County		10c City	y, Town or Lo	pation					1	10d. Inside City Limits
Viarylar	tified a	recto	MD	Balt:	imore		tonsvi							1 🗆 Yes 2 🄀 No
with the	ust be no	eral Di	10e. Street and Numb 70 Me11					10f. Zip Code 2122	28		11	0g. Citizen of USA	What Cour	ntry?
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.	irai , or items I Examiner m	Completed by Funeral Director	11. Marital Status U  1  Never Married  3  Widowed 4	d 2 $\square$ Marrie	Armed For	9	1	Vas Decedent of Hir Yes, specify Cub	an, Mexican Specify:	, Puerto Rica	Yes or No- an, etc.)		ace - Americ ack, White, fy: whi	etc. Lte
1215-( hin 72 hou	Medica	omplet	(Special Special Speci		grade completed) College (1-	4 or 5+)	(Give I	lent's Usual Occup kind of work done O NOT use retired,	during most	of working		16b. Kind of	Business In	dustry <b>unk</b>
ind 21 e filed with	event, th	To Be C	unk 17. Father's Name (Fir	st, Middle, Las	unk unk				18. Mothe	er's Name (Fi	rst, Middle, M	aiden Surnar	ne) <del>UI</del>	<del>ak</del>
Baltimore, Maryland 21215-0036  Dermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene.	r traumatic		19a. Informant's Nam		(Type, Print) erson – d	laughtei		g Address (Street	and Numbe	er or Rural Ro	ute Number, (	City or Town,	State, Zip (	Code) unk
imore, Page 1 and nent of Hea	and in them		20a. Method of Dispo	sition Cremation 3	Removal from	20b. P	lace of Dispo	sition (Name of natory or other pla	ce)	Date	2	20c. Location	n - City or To	own, State
Balti permit. Departi	any inju		21. Signal e Fune	ral Service ic	ensee	Žirecto	r 22	. Name and Addre				-		21201
Exam  Te be executed wisitian and wisitian and	dical niner	dical Examiner	23a. Part shock or heart in mediate Cause (Findisease or condition resulting in death)  Sequentially list conditions, leading to him cause. Enter Underly Cause (Disease or iin that initiated events resulting in death) La	failure. List onlinal	a. Athle Due to (c	ch line.	erotic	Card.c						Approximate Interval Between Onset and Death
JACA Box	ched for use as the	₿	IF FEMALE: 23b. Was decedent print the past 12 mo 1 Yes 2 9 Unknown	onths?		Birth 2 🗌 Feta nant at time of c	I death 3	Ectopic pregnan	су				ate of deliv	ery Day Year
Cords, P.O. law requires that the as been signed by the assern signed by the assert signed by	be detached	d by Pr	Part II. Other signific		a contributing to de	_	ulting in the u	nderlying cause gi	iven in Part I	i.				he cause of death?
Records The law requirate has been	irector, page 2 should be	omplete	High	Cho	lester					\\\	24a. Was an autopsy perform	ned?	. Were auto prior to co death? 1  Yes	psy findings available empletion of cause of
ian: T	ctor, p	Be	25. Was case referred examiner?					26. P	lace of Deat	th (Check onl		₩ 140]	1 🗆 100	
K Vitt	al dire		1 ☐ Yes 2 ☐	No No		npatient 2			4 L Nu		5 Resider			/)
ding F	funera	ate		5 Pending		of injury h, Day, Year)	28b. Time of injury	28c. Injui wor M 1 —	ryat k? ]Yes 2 □		. Describe how	v injury occu	rred	
Division of Vital of the Hospital or Attending Physician: within 24 hours after death.	ed in by the	l Certificate: To	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determine	t be 28e. Place	of Injury - At ho g, etc. (Specify,		eet, factory, office	Tes 2 🗆	_	Location (Stre City or Town,		ber or Rura	l Route Number,
he Hospit iin 24 hour	npleted fills	Medical	(Check 2 only one) 3	Medical Exa Certifying N	hysician: To the beaminer: On the basi urse Practioner: T	s of examination	and/or invest	igation, in my opini	on, death oc	curred at the	time, date and	place, and d	ue to the ca	use(s) and manner stated
Tot	LIOS		29b. Signature and titl	e of certifier	3000	0 - 1	ms	29c. Licens	e number	· ) [ ]	29	d. Date sign	ed (Month,	Day, Year)
			30. Name and address								a. i	· Man	11/1	D 21229
	State	е	31. Date filed (Month,			egistrar's Signat		Red	nvui	nuy	WIT	MOA	4 , 11	المالية

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:40FM las 201 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Ba Itimore Medical Center 8. Date of Birth (Month, Day, 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Country) **Director** Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits агллелі of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director ec11 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 903 Funeral BROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

Yes 2 If Yes, Give 2 No AJE Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩idowed 4 Divorced force Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) US AIR Force Elementary/Seconday (0-12) College (1-4 or 5+) STAFF SAFGEANT Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ၉ NICHOLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 OSED 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the dishock, or new failur Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death Ph\_sician/ 0 cemi D Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death Other (specify) signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed should been : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No After this certificate I funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗹 No 1 🔲 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗀 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 108394 5851 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, MD 21201 10 N. Greene Street ong MAD 31. Date filed (Month, Day, 32. Registrar's Signature State 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28792 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2011 11:00 PM 20 NAUD August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie Burnie Health & Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 18, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral 2**¹⊠M 2□F 1944 Months Maryland 66 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other thanmatic event, If the Medical Examiner must be notifiled at any Injury or other thatmatic event, If the Medical Examiner must be notifiled at 14 Yes 2 No Baltimore Director MD 10f. Zip Code 21226 10g. Citizen of What Country? USA 10e. Street and Number 1124 Hilltop Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 4/7/68 14. Race - American Indian. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced 4/12/68 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) home improvement tile setter unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Allers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Pages 1 and 2. Thent of Health and 27 is 1124 Hilltop Rd; Baltimore, MD 21226 Tammy Armstrong - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility State Anatomy Board Signaluse of Funeral Service Licenses Wad 655 W. Baltimore St; Baltimore, MD 21201 23a. Pak 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LEG AND soquentially list on different if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is doubt), act Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Month Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica ANA TONICA 2 No posta director, 25. Was case Be 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) PONK4D funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

State Registrar 29b. Signature and title o

30. Name and address of person who completed cause of death (Item 6 Year

2 2011

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Paul Brice Jr. 06 09 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Date of Discontinuous (Month, Day, 17 Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F Months Hours Min 62 Yrs. **Director** 213-52-4011 49 MD Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2X No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ems 23a or r must be r Funeral U.S.A. 1742 Glen Ridge Road 21234 items ! permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Narried Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade 2yrs Front Desk Clerk Hill Sales Corp. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Brice Sr. Catherine Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Brice-Wife 1742 Glen Ridge Road, Parkville, Md 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4 [ On-Site 9/8/2011 Baltimore, of Funeral Service 22. Name and Address of Facility
March F/H West 21. agnat 4300 Wabash Ave Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Approximate Interval Between or heart failure. List only one cause on each line Immedia Cause (Final disease or condition resulting in leath) set and Death Ph\_sician/ mens 2767 Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding which: P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 \sum Yes 2 Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ရ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Yea. MO Name and address of person who completed cause of death (Item 23a) (Type,

/ DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ E. Brantley 09 2011 11:27p.M  $\Omega$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Catonsville Frederick Villa Nursing & Rehat If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Hours 1 M 2 TXF Director 83 30 225-44-9565 Usual Residence of Deceden show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral Page 1 and 2 should be filed within 72 hours after death with 21229 U.S.A. 820 South Caton Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2X No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Domectic 7th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ္ Beatrice Thrower Jausha Barnes injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Silverthorn Road, Baltimore, Md 21239 James Barnes-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 9/7/2011 Carmel Baltimore, Md permit. 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Signatu of Ineral Service Licenses 21215 Baltimore, Md 3a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): -transit Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ↓ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has k autonsv performed? Yes 2 No page death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 XNO Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 To the F only one) 29c. License number 29b. Signa 2011 nd address of person who completed cause of death (Item 23a) (Type, Print) 00 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28795 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JESSIE HILDRETH BURTON Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12007 Scaggsville Road Fulton Howard Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 215-24-9796 83 1 □ M 2 XX Vrs Mar 21, 1928 Maryland Usual Residence of Decedent 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Fulton Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 12007 Scaggsville Road 20759 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2XXNo If Yes, Give Year or Dates Specify: Caucasian Completed 3 XXVidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12)
Grade 11 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Romaine Catherine Stonesifer Irving Luther Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is Clumbia, Maryland 21044 Robin Burton daughter 6332 Daring Prince Way Baltimore, 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Union Cemetery Burtonsville, Maryland 9/2/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Maryland 20707 M00770 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. Let only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DOMENTIA DARC ADVANCED Medical Due to (or as a consequence of) Examiner REBROVASCULAR Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Cause (Disease or injury HYPERTENSION death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed Yes 2 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation filled in by the 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifler 10 gr

Registrar DHMH 17 Rev 06-2011

State

Box 68760

of Vital

Division

PATH CHARLES STROET BALTIMIRE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Dep	partment of Health and leartificate of Death	, ,	giene Reg. N2 0 1 1	28796
			Registrar  1. Decedent's Name (First, Middle, Last)	ortificate of Death	2. Date of Dea		3. Time of Death
	Physicia Medic		Jean M. Brakefield		Month Septembe	Day Year	6:08 P M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			3903 Foreston Road	Beltsville		Prince G	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry)
			Usual Residence of Decedent		12/11/1	L926   Pe	nnsylvania
	/land f sho	tor	10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mar 7 28a- 7 Mar 7 28a-	Director	MD Prince Georges Beltsvi				1 ☐ Yes 🕅 X No
	ith th			10f. Zip Code		10g. Citizen of What Co	ountry?
	ems ?	Funeral	3903 Foreston Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	20705  Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	erican Indian
ဖွ	ter de , or it	by F	1 ☐ Never Married 2 ☐ Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rićan, etc.)	Black, Whit	e, etc.
8	urs af tural" al Exa		3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: W	hite
7	72 ho "na" n	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	king	16b. Kind of Business Verizon/	Industry
712	vithin liene.	Con	College (1-4 or 5+)	DO NOT use retired)		Telecommu	nications
٦	filed valued that the state of	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	Maiden Surname)	
<u>ya</u>	ld be Ment arked atic e	2	John Billett	Ethel M	urray		
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			ling Address (Street and Number or Rui			
9	and 2 Healt tem 2 ther 1		Neil Brakefield / son 4804  20a. Method of Disposition 20b. Place of Disp	Danbury Circle E	lDorado I	Hills, CA	
nor	age 1 ent of nt: If ii y or o		1 ☐ Burial 2 XX remation 3 ☐ Removal from State cemetery, cre	ematory or other place)		,	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot			andel Crem. 9/7/ 22. Name and Address of Facility		Odenton, Ma	aryland
m	Der Jung		/ M00770	22. Name and Address of Facility Donaldson Funeral 313 Talbott Avenue	Laurel	A. , Maryland	20707
			23a. Part 1. Enter the diseate, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
1	Physician/		Immediate Cause (Final disease or condition Acute Myelocytic	Leukemia			Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c.				
	te be executed iysician and ne burial-transit	Ĕ	resulting in death) Last  Due to (or as a consequence of):				
9	5 ≥ e	dical	d				
687	certifica anding pl use as tl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
	death c he atten ed for u	iciar	in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy     Other (specify)		23d. Date of de Month	Day Year
	v requires that the de been signed by the should be detached	Physician/Med	9 Unknown				
P.O.	s the	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to	
rd S	equire een si ould I	sted			1 🗆 Y	es 2 <b>XX</b> No 3□F	robably 4 🗌 Unknown
<u>ဂ</u>	law rahas b	Completed			24a. Was a autops	sy prior to	topsy findings available completion of cause of
Vital Records,	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical		perfor		s 2x1x No
/Ita	/sicial s certi	To Be	examiner? 1	26. Place of Death (Chec		ence 6 Other (Spec	:::1
o	ng Phy ter this		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at		ow injury occurred	сну)
0	eath. or: Af the fu	ifica	MAS Natural     5 □ Pending     (Montin, Day, Year)     Injury       2 □ Accident     Investigation       3 □ Suicide     6 □ Could not be	work?  M 1 ☐ Yes 2 ☐ No			
Division of	or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
2	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	nd due to the cau	se(s) and manner as st	ated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invenience only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	it the time, date an	d place, and due to the	cause(s) and manner stated.
	Vithi Com		29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mont	h, Day, Year)
	Man 1		Muchael ( Heard, Mi)	D 26287		September	6, 2011
_	John		30. Name and address of person who completed cause of death (Item 23a) (Type,		0-11	Dest.	30740
	Stat	е	Michael Berard, M.D. 7305 Baltimore 31. Date filed (Month, Dey, Year) 32 Registrar's Signature		College	Park, MD	20740
	Registra		SEP 1 2 2011 Jame S. S.	arkel			

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene o

		1 - For State Of Maryland / Bop Registrar	rtificate of Death		eg. No.	28/9/
Physic				2. Date of Death 9 Month	08 <sup>ay</sup> 2019	3. Time of Death 4:34 A M
Med Exam	dical niner		4b. City, Town, or Location of Death		4c. County of Deat	
Funera		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 1 M 2 XF 84 Yrs.		8. Date of Birth	9. Biri	thplace (State or Foreign untry) Virqinia
		Usual Residence of Decedent			<i>321</i>   W.	10d. Inside City Limits 1  Yes 2  No
with the I	Funeral Director	10e. Street and Number 138 Mountain Hill Rd.	10f. Zip Code 21903		0g. Citizen of What Co	ountry?
Daluffill Ofe, IMarylating Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	٤	1 Never Married 2 Married 1 Yes 2X No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
AIAID 72 hou within 72 hou giene. er than "nat the Medica", the Medica	Completed		edent's Usual Occupation kind of work done during most of wor OO NOT use retired) OCET	king	16b. Kind of Business Footwear	Industry
Tand J be filed fental Hyg irked oth	7. BB		•	ne (First, Middle, M Asbury	aiden Surname)	
Mary d 2 shoulk alth and N 27 is ma			ing Address (Street and Number or Ru Mountain Hill			
Darumit. Page 1 an Department of He Important: If iten any injury or other		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition cemetery, cre  Harford	osition (Name of matory or other place) I Mem Gdns. 9/1		20c. Location - City or Aberdeen	Town, State
Dermit. Departi	once	21. Signature of distribute e	2. Name and Address of Facility Parring-Cargo F 133 S. Parke St	uneral	Home	21001
Physician		23a. Part 1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Medica Examine	er	resulting in death)  Due to (or as a consequent soft to the conditions, b. In the conditions, b. In the conditions, conditions	1 Hemorri	1age	ji .	Minuts
cuted and transit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				5 Hours
ficate be executed g physician and as the burial-transi	Aedical E	resulting in death) Last  Due to (of as a consequence of):  d.				years
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
quires that then signed by all do detact	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to s 2 🖾 No 3 ☐ F	o the cause of death?
The law requires ate has been signated page 2 should b	Completed			24a. Was an autopsy perform	y prior to ned? death?	rtopsy findings available completion of cause of s 2 □ No
ysician: ysician: is certific director,	To Be	25. Was case referred to medical examiner?	26. Place of Death (Che		nce 6 Other (Spec	cify)
Attending Ph r death. ctor: After th y the funeral	Certificate:			28d. Describe hov		
tal or Atters after de al Directo			reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	iral Route Number,
the Hospition 24 hour the Funers	Medical	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death conditions on the basis of examination and/or inversely conditions on the basis of examination and/or inversely conditions. To the best of my knowledge, death conditions on the basis of examination and/or inversely conditions.	stigation, in my opinion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.
To t		29b. Signature and title of certifier Mo Physician	D70316		Eptember	
		ao. Name and address of person who completed cause of death (Item 23a) (Type, DR. Ann Lager Lund 104 B	ow St. EIKto	n MID	2192	-1
S Regis	tate trar	31. Date filed (Month, Day, Year)  SEP 1.2 2011  32. Figures Signature	harles	<i>I</i> —		
HMH 17 Bey 7	7/2000					

		1	For State Registrar	State of Ma	aryland / Del	partment of l ertificate of		, ,	giene leg. No 2011	28798		
	hysicia /Medic	_	1. Decedent's Name (First, Middle Edith	, Last) Theresa	Bot	saris		2. Date of Deal Month Septem	Day Year	M		
	xamin	er	4a. Facility Name (If not institution Genesis Health	, give street and number)  Care		4b. City, Town, o	or Location of Death  Park  If Under 24 Hrs.		4c. County of De	ath		
	neral ector		5. Social Security Number  217–20–6594  Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2X F	e (In yrs. last birthda 85	Months Days	Hours Min.	8. Date of Birth (Month, Day 7/10/1	926 M	laryland		
Maryland	fed at	tor	10a. State 10b. County	Arundel	10c. City, Town or Pasaden					10d. Inside City Limits 1 □Yes 2 ☒No		
with the	3a or 28e	I Director	10e. Street and Number  150 Cottage Gro		1 dodda	10f. Zip Code 21122		1	U. S. A.	Country?		
11215-0036 within 72 hours after death with the Maryland lene.	an "natural", or items 23a or 28a-f show Modral Examinat nambe retified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?		3. Was Decedent of I	oan, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		nerican Indian, ite, etc. White		
21215-003 within 72 hours a	F.3	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education tt grade completed)  College (1-4or 5	(Gi	cedent's Usual Occu ve kind of work done b. DO NOT use retire er / Opera	during most of worked)	king	16b. Kind of Busines	s/Industry		
yland 2  yland 2  yld be filed  Mental Hygi	E E	Be	17. Father's Name (First, Middle,		OWII	or / Opene	18. Mother's Nam		Maiden Surname)			
laryla 2 should and Men	is mark	၉ .	Jerome Thun 19a. Informant's Name/Relationsh		19b. Ma	ailing Address (Stree	Emilie t and Number or Ru		licka r, City or Town, State	, Zip Code)		
Baltimore, Maryland 21  Dermit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier	If item 27 is marked o or other traumatic eve		Michael Stepher  20a. Method of Disposition  1 MBurial 2 Cremation	·	20b. Place of Dis	1 Brad Cou sposition (Name of rematory or other pla	i	Date	ryland 211 20c. Location - City	22 or Town, State		
Baltim permit. Pa Departmen	Important; Il any injury o once.	ŀ	4 ☐ Donation 5 ☐ Other (S)		Gardens	of Faith	ess of Facility	_	Overlea,			
m aa.	<b>≣ %</b> 8	-	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	) Sř the death. Do not		ski Funera Eastern <i>A</i> ing, such as cardiac			yland 21221  Approximate Interval Between		
🏅 /Me			Immediate Cause (Final disease or condition resulting in death)	a. ad	_		mention			Onset and Death		
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):							
ocrtificate be executed	the bur	dical	d									
O. Box 6.	detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2  Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)		23d. Date of Month	delivery Day Year			
ecords, P.O. Bo	be d	þ	Part II. Other significant condition	ens contributing to death b	Failur	e underlying cause gi	iven in Part I.			to the cause of death?  Probably 4 Unknown		
<u>~</u>	page 2	Completed							prior death			
	<u>υ ≔</u>	To Be	25. Was case referred to fiedical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpa	tient 3 DOA Ot	hor	ath <i>(Check only o</i> llome 5 🗆 Resid	<i>ne)</i> dence 6 □Other (S	pecify)		
ding .	funera	ation:	27. Mann of Death  1 atural 5 Pendin investig	ation	ury 28b. Time ny, Year) Injur	y Wo	ury at ork? ⊒Yes 2 □ No	28d. Describe h	now injury occurred			
DIVISION ital or Attending	completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place of in building, el	ury - At home, farm, ic. <i>(Specify)</i>			City or Tow				
ne Hospital	oletely fi	Medical		g Physician: To the best Examiner: On the basis of and manner st	of examination and/o							
To the	E S	ğ	29b. Signature and title of certifier	M			1507Q		29d. Date signed (Mo			
,	3		30. Name and address of person	who completed cause of	death (Item 23a) (Typ	pe, Print)	Hum	11:11-		- 2011 MD2/108		
	Stat	te	31. Date filed (Month, Day, Year)	33. Registi	rar's Signature	or ar are	,,,,,,	viue	rsville	, , , , , , ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 3 Physician/ 2011 <u>Yvonne Bernadette Bloomer</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F (Month, Day, Year) 19 17, 1939 Hours United Kingdom Director 220-50-7404 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 20906 ò 10g, Citizen of What Country? ral", or items 23a or Examiner must be Funeral 12902 Matey Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiens. Important if item 27 is marked other than "natural", Important if item 27 is marked other than "any injury or other traumatic event, the Medical Exal any injury or other traumatic event, the Medical Exal Completed Specify: 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) healthcare nurse Be 17. Father's Name (First, Middle, Last) th and Mental h 18. Mother's Name (First, Middle, Maiden Sumame) 0 Elizabeth Newsome Charles Herry Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12902 Matey Rd; Silver Spring, MD 20906 Lewis Bloomer - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specif of Huneral Servic KOHA I O Prector Signa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ASCVD disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month signed by the a g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Dunknown chronic renal failure Completed multiple myeloma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate ha 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🗌 Yes ၉ 1 Inpatient 2 X ER/Outpatient 3 IDOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12:17 PM

10d. Inside City Limits

Approximate

Day

29d. Date signed (Month, Day, Year)

9/2

Year

Interval Between Onset and Death

white

1 🗆 Yes 2 🔀 No

State Registrar only one

29b. Signature and title of certifie

DHMH 17 Rev 7/2009

Carolyn Sporn 1500 Forest Glen Rd; Silver Spring, Maryland 20910

w

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D5864

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #184a Per PHY C919 9/12/2011 JH &10e 3 are of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Harry **Bouwens** Year Physician/ Month 00 1017 A M D Medical 4c. County of Death Examiner Mare intitution gire MD Medical Center 4b. City, Town, or Location of Death N/AMOYC 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 Year **Funeral** 1 □XM 2 □ F Months Days Hours Min 0171371953 Yrs. **Director** 264-08-0462 58 NY Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD HOWARD ELKRIDGE 10e. Street and Number Harthorne 10f. Zip Code 10g. Citizen of What Country? Funeral 6418 HAWTHORNE AVENUE 21075 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry at filed wn... rtal Hygiene. خو**r than** "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th FUNERAL HOME 10 FUNERAL ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment.
Important: If item 27 is marked any injury or act. HARRY BOUWENS DEE MASKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6418 AVENUE, ELKRIDGE, MD 21075 CONNIE JEAN BOUWENS/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION INC 09/09/2011 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Cenns 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to or a a consequence of): Examiner Neells itwo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diséase or iinjury that initiated events resulting in death) Last Examiner ententom Hospital or Attending Physician: The law requires that the death certificate be executed Neells attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical The month antral Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Id be detached fo 1 Yes 2 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peens should 24b. Were autopsy findings available 24a. Was an cate has page 2 s prior to completion of cause of death? performed? 1 ☐ Yes 2 ☑ No this certificate Yes 2 After this certification of the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} Hospital: 1 ☐ Yes 2 ☐ No ပ 1 La Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☑ No NA in 24 hours after death.

In Funeral Director; At objected filled in by the fu NIA ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined NIA Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year, address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 1, Day, Year) 12 2011 32. Registrar's Signature State Registrar

		•	For State Registrar	State of Maryla			nt of He e of De			giene Reg. N2. ()		28801
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	Dav	_ Year	3. Time of Death
	Medic Examin	al	BLANCHE RUTH  4a. Facility Name (if not institution, give sti	BROOKS reet and number)		4b City	Town or Le	ocation of Death	SEPTEM		2011 nty of Deat	
	) Examin		ENVOY OF PIKESV	· ·			ALTIM				LTIMC	
	Funeral Director		213-16-0001	M 2 🖾 F 7. Age (In yrs.	last birthday) Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Birt 11/2/2/7	1 <sup>7</sup> 922		thplace (State or Foreign untry) MD
	and show at	ō	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Maryla 28a-f	rect	MD BALTIM	ore o	WINGS M	ILLS						1 ☐ Yes 2 🙀 No
	th the 3a or t be n	al D	10e. Street and Number			10f. Zi	o Code			10g. Citizen o	of What Co	ountry?
	ems 2	Funeral Director	3440 ASSOCIATED 11. Marital Status 1	2. Was Decedent Ever in U	I.S. 13. V	Nas Dece	21117 dent of Hisp	panic Origin? (Spe	ecify Yes or No-	US.		rican Indian,
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	f Yes, spe	cify Cuban, 2 <b>K</b> No	Mexican, Puerto	Rican, etc.)		lack, White	
2-0	2 hour "natu	Completed	15. Decedent's Edu Specify only highest grade	cation completed)	16a. Deced	kind of wo	rk done dur	on ing most of work	ing	16b. Kind of	Business	Industry
72	vithin 7 iene.	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	0 NOT us NAGE	e retired)			PIIR	LTSHI	ING COMPANY
g	filed val Hyg	) Be	17. Father's Name (First, Middle, Last)					8. Mother's Nam	e (First, Middle,			002121111
<u> </u>	uld be d Ment marke natic	잍	BARNEY	KLOMPUS				DORA			SINGE	
Σ	d 2 shoalth an 27 is ir trau		19a. Informant's Name/Relationship (Type DIANE GARTNER/DA)	•		-		d Number or Rura RT, OWIN			ı, State, Zip 2111	
Baltimore,	of Head of Head if item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo	sition (Na	me of	1	Date	20c. Locatio		
<u>H</u>	t. Page tment rtant: I		4 Donation 5 Other (Specify)		LTBERTY SHAAREI	<u> ZIO</u>	N	109/09	/2011			rown, md
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licensee	atter	8	3900	REIST	of Facility SOI ERSTOWN	ROAD, P	IKESVI	-	
	Ph_sician/		23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the dea cause on each line.	ath. Do not ente		- 1	such as cardiac	or respiratory ari	est,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	1 3	10[]				$\neg$	7111107 63
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):							
	icate be executed physician and s the burial-transit	l Exar	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):							
09	ate be ohysicia the bu	edical	C d									
687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregr						23d	Date of de	livery
Box	the death y the atte ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown		Other (s	pregnancy pecify)				Month	Day Year
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions conf	tributing to death but not re	esulting in the u	Inderlying	cause giver	n in Part I.			-	the cause of death?
corc	law requas bee	Completed							24a. Was	sy	prior to	topsy findings available completion of cause of
Re	n: The ficate h		25. Was case referred to medical					-	1 🗆 Yes	rmed? 2 No	death?	s 2 No
Vita	ysicial is certi directo	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐	FB/Outpatier	nt 3 🗆 D	Other:	e of Death (Chec	k only one) ome 5  Resid	lence 6 0	ther (Soar	Nife/)
0	ing Ph ifter thi ineral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		28c. Injury a work?		28d. Describe h			ary,
sion	ttendi death. stor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	arma form atm	M not factor	1 ☐ Ye	es 2 🗆 No	006		-	The state of the s
DIX	ital or A urs after ral Directled in by		4 ☐ Homicide determined	building, etc. (Speci	fy)				City or Tou	n, State)		ral Route Number,
)	e Hosp 24 hol e Fune leted fi	Medical	(Check 2 L Medical Examine	ian: To the best of my know r: On the basis of examinati Practioner: To the best of r	on and/or invest	tigation, in	my opinion,	death occurred a	t the time, date a	nd place, and	due to the	cause(s) and manner stated.
/	To the within To the comp	2	29b. Signature and title of certifier	ractioner. To the best of t	ny knowledge, c		. License n		ce, and due to th	29d. Date sign	ned (Montl	h, Day, Year)
			peron Steel	mi			0006	1199		Sept	, 7,	2011
•	) \		30. Name and address of person who con Jason Black Mi		m 23a) (Type, F	Print)	- Cv	to 4100	, Towas	MM	21	204
.29	Stat Registra	.0	31. Date filed (Month, Day, Year)  SED 1 2 201	32. Egistar's Sign	atura		7	40 11-4		, , ,	- 12	
	01-19 61 6		3EP 12 /III	1 1 1 10000	,507	MA ASTA						

DHMH 17 Rev 7/2009

amend #195 tate of Waryland 96 Partment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month **Physician** nni EPTEMPERA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES 8. Date of Birth (Month, Day, Year) BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. (In yrs. last birthday 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2**∀**F Director Washington, D.C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notifled at 1 des 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status item 27 Is marked other than "natural", or iten other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Blac 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Şecondary (0-12) College (1-4or 5+) Homemake Home Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) naton 19a. Informant's Jame/Relationship (Type. Printing ther) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Eutaw Place #708 Balto,MD 21217 Denn permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State crematory or other place) 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 2011 Woodlawn, MD ood lawn Cemeter 4 Donation 5 Dother (Specify) 21. Signature of Pun ral Service License 22. Name and Address of Home, P. MB 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HOURS ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORONARY ARTERY Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 les 2 lo No 24a. Was an autopsy performed? To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 □ No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated to the cause (s) and manner as stated to the cause (s) and place, and due to the cause (s) and manner as stated. 29a. Certifier Medical (Check only one) n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE, MOZIZZA REED K. 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N& U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** morne 1650 PM evoc 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arc. 815 Baltimore vedere Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hi 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1**2**M 2□F 7 227-46-0569 Director -6-1937 icainia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director tomor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ortant: If Item 27 Is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be r 215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tyres 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Completed by Blac 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Washer 4rrou permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic access \*\*\* Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ morne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Macbeth Balto. MD ethorn 6101 a 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Mills 4 □ Donation 5 □ Other (Specify) arrison 21. Signature of Funeral Service License and Address of Facility Ru SS Funeral-23a. Part. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be complicated to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be completed to the death. 21216 Immediate Cause (Final disease or condition resulting in death) MYOCARDI Physician /Medical Due to (or as a consequence of): **Examiner** DISTASE CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DIABETES burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 ☐ DOA 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIKESVIlle MD SADOVNIK 105 201 MILFORD MILL RD MIGUEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

SEP 1 2 2011

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year Mon 9/8/20 1 1 1:38 P M Marie Elizabeth Cardell Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Days Months Hours 671471914 Yre MD Director 341-22-2338 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b County 10c. City, Town or Location Director must be notified 1 Yes 2 X No Carrol1 MD Westminster 5 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 300 St. Luke's Circle USA 21158 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: "natural" Completed 3 Widowed 4XXDivorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Florist Retail Sales Representative 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Etta Elizabeth Cadle Emory Harrison Flowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Cardell/Son 1704 Peachwood Ct., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9/12/2011 Sykesville, MD 4 Donation 5 Other (Specify) Lake View Mem. Park Funeral Service Licensee 21. Signatu 22 Burrier Odern Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury UPou death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a detached f Unknown Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page performe death? 2 No Yes 25. Was case referred to medical examiner? Be director. 26. Place of Death (Check only one) Hospital Other: 2 No ၉ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28c. Injury at 28d. Describe how Injury occurred Certificate: Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State Medical wledge, death of 29a. Certifier 1 Certifying Physician: To the best of my k red at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exami ation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tion and/or inves (Check 3 Certifying Nurse death occurred at the time, date and place, and due to the cause(s) and manner as stated Practioner: To the be of my knowled

0

Box 68760

P.O.

**Division of Vital** 

State Registrar 29b. Signature and title of certifier

30. Name and address of persor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28805 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept. Physician/  $04^{\text{Day}}$ 2011 4:10P V. Ella Carroll Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care Homewood Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth 9. Birthplace (State or Foreign Birthplac Country) MD **Funeral** Month, Day, Year 1 ☐ M 2**X**☐ F Days Hours Min. 213-64-6426 92 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 No NA Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 21214 USA 4700 Harford Avenue 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African Armed Forces? ģ 1 Never Married 2 Married han "natural", ( If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: American Completed 3 Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Ejementary/Seconday (0-12) 12th Grade College (1-4 or 5+) the Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ൧ Green Ella Henson Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atlanta, GA. 30366 P.O. Box #80854 Danella Jones-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Baltimore Nat I 1 X Burial 2 Cremation 3 Removal from State 09-13-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last ı physician a s the burial⁴ Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Thinknown Completed has been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 410 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Hursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. work' 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, Division of Vital

Box 68760

P.O.

Baltimore, Maryland 21215-0036

State Registrar (Check

29b. Signature and title

3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

ockrilly mo-21234

11-06658 Ivory Corbett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | | 28806 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death **Medical Examiner** Month 0040 hrs Ivory Corbett September 4, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1102 Druid Hill Avenue Apt. 1412 Baltimore 5. Social Security Number 6. Sex 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. oreign Country) NC Months Min Director Days Hours 218-58-2542 59 01-05-52 1 X M 2\_\_\_F Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1X Yes 2 No "natural", or items 23a or 28a-f sho | Examiner must be notified at once. MD NA Baltimore more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #1412 1102 Druid Hill Avenue Apt. 21201 Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. African Yes 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: American 含 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical. 12th Grade NΑ Custodian Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Martha Pearl Corbett 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Yarbrough-Brother 8014 Sagramore Road Rosedale, MD. 21237 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09-10-11 Randallstown, MD 4 Donation 5 Other Specify: King Mem. Pk. 21. Signature of Euneral Service Licens 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 26a-Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Division of Vital Records, P.O. Box 68760, Physician/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached f Part II. Other sig ifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l be deta þ Diabetes Mellitus 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy has prior to completion of cause of performed? death? certificate Yes 2 V No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: Pending 1 Yes 2 No filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day Year) O.C.M.E. September 7, 2011 mell techell 30 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature 35 Date filed (Month, Day Year) State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar	e or marylane		tificate of D		F	eg. N2 (		28807	
ı	Physicia Medic		Decedent's Name (First, Middle, Last)  Do	lores Glo	ria	Clark		2. Date of Dea Month Sept.		011 <sup>Year</sup>	3. Time of Death 2:00 P M	
er eg	Examin		4a. Facility Name (if not institution, give street and			4b. City, Town, or		h		unty of Death	ma Co	
	Funeral		Franklin Square Hosp 5. Social Security Number 6. Sex	ital Ctr. 7. Age (In yrs. Ias	t birthday)	Rose	If Under 24 Hrs		1		re co.	
	Director		219-18-2513  Usual Residence of Decedent	86	Yrs.	Months Days	Hours Min.	July 17	Year) 1,1925	Coun	yland	
	Maryland 8a-f shoritified at	rector	10a. State 10b. County 10b Baltimore	10c. City,	Town or Loc	cation	Dunda	alk		1	0d. Inside City Limits 1 ☐ Yes 2X No	
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 2011 Jasmine Road			10f. Zip Code	222			of What Cour ed Sta		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If fine 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	þ	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. d Forces? Yes 2 XNo , Give or Dates.	li li	Was Decedent of His f Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	Black, White			
Baltimore, Maryland 21215-0036	in 72 hour e. nan "natu	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	pted)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of wo	rking				
21	d with ygien her th nt, the	Be C	5 Years		Hom	emaker				Home		
and	be filed antal Hy ced oth c event	To B	17. Father's Name (First, Middle, Last)  William Chappell					me (First, Middle, I Mancuso	Aaiden Surn	ame)		
aryl	should be file and Mental   7 is marked or raumatic eve		19a. Informant's Name/Relationship (Type, Print)	[]	19b. Mailin	ng Address (Street a	nd Number or Ru	ıral Route Number	City or Tow	n, State, Zip C	Code)	
Σ	and 2 sl Health a tem 27 i		Mrs. Lynn Gover (Daug	hter)	405	Weatherby	Road	Bel Air,	Mary1	and 2	1015	
lore	permit. Page 1 and Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State cer	netery, cren	sition (Name of natory or other place		Date		on - City or To		
Itir	artmer ortant injury		4 ☐ Donation 5 ☑ Other (Specify) En to 21. Signature of Funeral Service Licensee	mbment Hol								
Ba	Departing Departing Impo		Except ER	_ <del></del>		Dudaukuuk 7922 Wise						
23a. Part 1. Enter red disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart aliure. List only one cause on each line.  Immediate Cause (Final disease or condition							Approximate Interval Between Onset and Death					
Name of the Party	Medical Examiner		resulting in death) Du	e to (or as a conseque		y Trac	+ I	nfer t	150			
		iner	Sequentially list conditions, if any, leading to immediate Du cause. Enter Underlying	e to (or as a conseque	nce of):	100						
	fificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c	Disease or injury								
0	be ex sician buria	calE	d d									
8760	ificate ng phy as the	Medical	IF FEMALE:								-	
. Box 6	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death state death in 10 the Funeral Director. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	, outcome of pregnand Live Birth 2 ☐ Fetal o Pregnant at time of dea Unknown	death 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d.	Date of delive	ery Day Year	
ls, P.O.	uires that thas a signed by all doe deta	by	Part II. Other significant conditions contributing	to death but not result	ting in the u	nderlying cause give	en in Part I.				ne cause of death?	
ecorc	ne law require e has been si age 2 should l	Completed						24a. Was a autop	med?	prior to col death?	osy findings available mpletion of cause of	
alF	ician: The certificate rector, pag		25. Was case referred to medical examiner?			26. Pla	ce of Death (Che		2 No	1 L Yes	2 LI NO	
Ξ	Physic this ce al dire	ု	1 Yes 2 Yo Hospital:	Inpatient 2	R/Outpatien 8b. Time of		4 U Nursing I	Home 5 Reside				
0 0	nding I th. : After e funer	cate		Date of injury  Month, Day, Year)  2	injury	28c. Injury work? M 1 🗀		28d. Describe ho	w injury occ	curred		
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	l Certificate:	3 Suicide 6 Could not be	lace of Injury - At hom uilding, etc. (Specify)	e, farm, stre			28f. Location (Si City or Town		mber or Rural	Route Number,	
	he Hospi in 24 hou he Funer: pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To t 2 Medical Examiner: On the 3 Certifying Nurse Practiti	basis of examination a	and/or invest	igation, in my opinior	n, death occurred	at the time, date an	d place, and	-due to the cat	use(s) and manner stated.	
	Voith com	20 <del>.</del>	29b. Signature and title of certifier  ChwK 5 55	MI	)	29c. License	number 140°	7	29d. Date sig	gned (Month, I	Day, Year)	
	29		36 Name and address of person who completed	cause of death (Item 2	3a) (Type, P	Ma ce	Ave	nue,	Balt	imore	MD 21221	
ı	Stat Registra		31. Date filed (Month, Day, Year) SFD 1 2 2011	2 Registrar's Signatur	1. 160	ake						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 28808 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $\mathbf{P}^{\mathsf{M}}$ hie James SEPTEMBER Medical 201 4:10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year Security Number If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours 216-20-4626 **Director** Usual Residence of Decedent or 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21234 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force 1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or 2 No 1 ☐ Yes 2 ☑ No Specify 3 🗌 Widowed 4 🗀 Divorced Black Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) le r Be Maryland Eather's Name (First, Middle, Last) 3 18. Mother's Name (First, Middle မ na Teh OX Informant's Name/Relationship (Type, F 19b. Mailing Address (Street and Number or Rural Route Number read on Baltimore, 20a. Method of Dispositi 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fundral Service Licens 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Ischemic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner thany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 2 🔲 No 1 Yes the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation M **Director:** Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie D0043489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 N. Charles St. 31. Date filed (Month Day State Registrar ₩ DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien 20 |

2880	9
------	---

		•	1 - State Registrar		,	Cei	rtificate of l	Death	Reg	g. No.		
	Physicia		1. Decedent's Name (First, Middle	, Last)					Date of Death     Month	Day Y	'ear	3. Time of Death
	Physicia /Medic		E	glantina	Co:	rfidi			Septembe			4:30 A M
	Examin	er	4a. Facility Name (If not institution	_	•			r Location of Death		4c. County of		
- A Principal	£		Riverview Nursi		Cente:		TOWS	If Under 24 Hrs.	8. Date of Birth		timo	ore place (State or Foreign
	Funeral Director		166-03-3051	1 □ M 2 1 F	91	Yrs.	Months Days	Hours Min.	Oct. 11,	1919	Cour	aly
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Lo	cation				1	0d. Inside City Limits
	aryla shov	'n					cation					1 ☐ Yes 2√∑ No
	the M	Director	Maryland Balt  10e. Street and Number	imore		<u>Essex</u>	10f. Zip Code	<del></del>	10	g. Citizen of Wh	at Cour	
	with la or			Daad			·	21286		U.S.		Í
	ns 2%	Funeral	1431 Providen	12 Was Decede	nt Ever in U.S.	. 13.		Ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race -	Americ	
9	or ite		1 X Never Married 2 ☐ Mari	Armed Force 1 ☐ Yes 2 [ If Yes, Give	X No		1 ∐Yes, specity Cuba 1 ∐Yes 2 X No	an, Mexican, Puerto  Specify:	Hican, etc.)		White,	
93	ral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:					Specify:	Whi	
2-	72 h "natu	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	- 1	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work		6b. Kind of Busi	ness/in	dustry
12	within ene. <b>than</b>	шc	Elementary/Secondary (0-12)	College (1-4c	or 5+)		eamstress	<i>'</i>	[	epartme	nt.	Store
о 5	filed Hygi other	o Cc	17. Father's Name (First, Middle,	Last)			eans tres		e (First, Middle, M			
au	ld be lental ked c	To Be	Pau1	Corfi	idi				Catherin	ne	Pao	li
ary	shou and N s mar umat	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, S		
Ž	and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hyglene.  n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Madical Exeminations the rediffical at		Michael J. Gian	nerini Nep	ohew	1431	Provider	nce Road	Towson,			21286
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madoel Examinar must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3  Removal from Sts	20b. Pla	ace of Dispo	sition (Name of matory or other place ALLEY	ce)	Date 2	0c. Location - C	ity or To	own, State
<u>Ē</u>	ment ment ant: I		4 Donation 5 Dother (S	pecify)	Mer	morıa.	L Gardens	: :9 <del>-</del> 12-	-2011 T	imonium		Maryland
3aH	ermit repart nport ny in		21. Sign voice of Funded Service	Licensee		22	2. Name and Addre	ess of Facility Kl	ick Towso Towson, M	n runer Jarvland	ar 1	iome, 1nc. 1204
	TO = # 0		23a. Part 1. Enter the disease, or	Hayan	and the death						17	Approximate
E		a la	shock, or heart failure. List	only one cause on each	h line.	Do not en	ter the mode or dyn	ng, such as cardiac	or respiratory arre	, st,		Interval Between Onset and Death
duje	hysician Medical		Immediate Cause (Final disease or condition resulting in death)	_ae		2000	war	acude	ent			
*	Examiner		,	Due to (or	as a conseque							
	nis -	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dual to (or	DE D GURBURUN							
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· A	Laken	mer-	e der	ventic	_			
o,	e exectant arrial-tr		resulting in death) Last	Due to (or	as conseque	ence of):		-				
68760,	ertificate be executed ling physician and e as the burial-transit	Medical		d	teop	oves	13-				_	
30 ×	ertific ling p e as t	Mec	IF FEMALE:	00-14							4	
Вох	eath ce attendi for use	ian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No		me of pregnan th 2 ☐ Fetal on tat time of de	death 3[	☐ Ectopic pregnand ☐ Other (specify) _	СУ		23d. Date Mont		Day Year
P. 0.	the de	Physician	1 □Yes 2 ☑No 9 □ Unknown	9 Unknow		aui St	_ Other (specify) _					
σ.	uires that the de signed by the a d be detached f		Part II. Other significant condition	ons contributing to deat	h but not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	oute to	the cause of death?
rds	quires n sigi ald be	d by							1 ☐ Ye	s 2 No 3	∃□ Pro	obably 4 ☐ Unknown
00	aw requir s been s s should	Completed							24a. Was ar	24b. W	ere aut	opsy findings available
æ	sician: The law certificate has t irector, page 2 s	omp							autopsy perform 1 □ Yes 2	ned? de	eath?	ompletion of cause of 2 □ No
<u>ita</u>	ian: rtiffice stor, p	Be C	25. Was case referred to medica					26. Place of Dea	th (Check only one	, ,		
Ž	Physician: The la r this certificate has ral director, page 2		examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inp			ut 3 🗆 DOA		lome 5 Reside			ify)
פֿח	ing P	on:	27. Manner of Death  1 Natural 5 □ Pendir	ig .	Injury Day, Year)	28b. Time o Injury	Wor		28d. Describe ho	w injury occurre	d	
sio	ttend leath tor: /	cati	2 Accident investi		Injury At hor	me form et		]Yes 2□No	28f. Location (Str	reet and Numbe	ror Bu	ra I Poute Number
Division of Vital Records,	I or Attending Ph after death. Director: After th I in by the funeral	Certification: To	4 ☐ Homicide determ	ined building.	, etc. (Specify)	)	reet, factory, office		City or Town	, State)	0, 1141	arriogre Nambol,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ng Physician: To the be Examiner: On the basi								
	To the H within 24 To the F complete	Medical	one)	and manner			29c. Licens			9d. Date signed		
	5 × 5 × 0		29b. Signature and title of certifie					05517-1		O 9		
			30. Name and address of person	who completed access	of death /lta-	23a\ /Time		~ ) ! ! !			1 10	111
_			Sebastian		3023	Eas	tern a	cone	Boltim	ove Mi	o i	21224
	Sta	te	31. Date filed (Month, Year)	32.	etrar's Signatu		0.4.1					·
	Registr	ar	čen 1 C	ו לדחת נ	and a l	7. 43	arres					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28810 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2011 LEE CARTER 5:15 AM . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ENCORE at TURE VALLEY HOWARD COTT 5. Social Security Number 6. Sex If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **M** 2 □ F Month, Day, Year, Country) KLAHoma 82 Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HOWARD WOODBINE MO 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral WOODBINE ) SA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ★ Yes 2 □ No 1950 Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced 1954 Specify: WHITE Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DEPARTMENT OF Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 LUTHER CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1/529 STAR DUST LANE ELLICOTT CITY MO 2/042 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of h Important: If ite any injury or ot 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State 9/12/2011 4 ☐ Donation 5 ☐ Other (Specify) WOUSEINE, MO 21. Signature of Funeral Service Licensee

22. Name and Address of Facility 1 NZUMBUR

23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility UNZUM BWW = H & mov Co SYFESVILLERS ELDERSSURG-MB 21784 Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardioniscular Disease HMErosclerotic disease or condition resulting in death) aas Medical Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Demente and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown 2 No the a Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Number Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. R121680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 Cada e Lane

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month oste 5:50 AM helma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Baltimore** St. Elizabeths Nursing Home 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Oct. Ti, 1 M 2 W Months Days Hours Year 1919 Marwland Director 218-03-6951 91 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 3320 Benson Ave. 21227 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 XNo If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Cromwell Hasselbarth Marv permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2317 Tucker Ln, Baltimore, MD 21207 (Daughter) Judith Coster 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Encombment Loudon Park Cemetery 9/17/11 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) VM Medical Due to (or as a consequence of): . Examiner OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 00 s certificate has hadirector, page 2 s performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - Cer 12111615 9/6/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson Ave Goidsbowsh

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ Coberly Howard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Feb. 5, 1932 West Virginia 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 **X** M 2 □ F Months Days Hours **Director** 235-48-5634 Usual Residence of Deceder show 10a. State 10b. County the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2X No MD Anne Arundel Baltimore ō 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? 30 Funeral with 1 5709 Redmond St. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. the Medical Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Reserve Guard 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Summerfield Cober1v Alpha Arch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig 4413 Fox Chaser Ln, White Hall, MD 21161 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trai Deborah Bartkowiak (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/9/11 Loudon Park Cemetery Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Entombment 22. Name and Address of Facility Loudon Fark Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ō Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? No prior to completion death? page certificate I 2 1 No Yes 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 မှ ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury death. 1 Yes 2 No 2 Accident 3 Suicide Investigation М the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 6,2011 30. Name and address of person who completed cause of death (Item 27) (Type, Print) WUSP 31. Date filed (Month, Day, Year, State backer Registrar DHMH 17 Rev 7/2009

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 28813 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9/10/2011 Emma Jean Denney 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brinton Woods Health Care Center Sykesville Carrol1 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Min. Hours 9/26/1924 Director 298-16-7911 86 OH Usual Residence of Decedent 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Carrol1 Sykesville 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1830 D Vincenza Dr. 21784 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other tl 12 Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Greiner Mildred Eddy and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6009 Snowden Run Rd., Sykesville, MD 21784 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Shirley Griffin/Daughter other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State Carroll Crematory 9/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD Full eral Service Licenses 22. Burrier offer Funeral Home & Crematory, P.A. cerm 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Prit 1. Enjer the disease, or complications that caused hock, heart failure. List only one cause on each lipe immeriat cause (Final disease or condition sed the death. Do not enter the mode of ding, such as cardiac or espiratory arrest, Approximate Interval Between Onset and Death Physician/ Moure Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consectionce of cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? performed? Yes 2 No certificate 1 Yes 2 No To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No hours after death Accident Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Masse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed Month, Day, Year, 12

Registrar

DHMH 17 Rev 7/2009

State

address of person who completed cause of death (Item 23a) (Type, Print)

ul

ANRS

(Month, Day, Year)

2011

			State of Ma	aryland / Dep			Mental Hy	/giene		
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of	Death		Reg. No.2 0		28814
	Physicia	ın/					2. Date of D Month	Day	Year	3. Time of Death
	Medic Examir		Regina Mae Delaro  4a. Facility Name (if not institution, give street and number)		4b City Town	or Location of Dea		4c. County of	DII.	2:15 PM
_	LAGIIII	ic.	Franklin Square Hospi	401	Rose	4 .		Bal+		270
1	Funeral		5. Social Security Number 6. Sex 7 Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		rth	9. Birthp	place (State or Foreign
	Director		218-14-6291 1 □ M 2 🗓 F	87 Yrs.	Months Days	Hours Min	0ct 22	, 1923	Mai	cyland
	nd how at	Ļ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation					0d. Inside City Limits
	arylar a-f sl	ectc	MD Baltimore	Parkvill					l'	1 Yes 2 No
	or 28	į	10e. Street and Number	T GIRVIII	10f. Zip Code		-	10g. Citizen of W	hat Cour	
	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	Funeral Director	3203 Sperl Court		21234			USA		,.
	death items ier m		11. Marital Status 12. Was Decedent Example Forces		Was Decedent of H	lispanic Origin? (S	Specify Yes or No			
36	after (", or	<u>ş</u>	1 Never Married 2 Married 1 Yes 2 1	No	lf Yes, specify Cuba 1 ☐ Yes 2 🛣 No		to Rican, etc.)		, White, e <b>whit</b>	
8	ours artural	Completed	Year or Dates.					Specify:		
5	72 h in "ni Medio	ď	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wo	orking	16b. Kind of Bus	iness Inc	dustry
212	within giene. er tha the I	ပိ	Elementary/Seconday (0-12) College (1-4 or 5-	+)	sewife			own h	ome	
b	filed all Hyg	Be	17. Father's Name (First, Middle, Last)	•		18. Mother's Na	ame (First, Middle	, Maiden Surname)		
Maryland 21215-0036	e 1 and 2 should be file of Health and Mental F f item 27 is marked o r other traumatic eve	은	Patrick Anthony Hannon			Margu	erite Ca	therine	Hohm	ann
Лaг	shou and is m raum		19a. Informant's Name/Relationship (Type, Print)					er, City or Town, Sta	ite, Zip C	Code)
e)	and 2 Health em 2: ther t		Joseph J. Delaro – son  20a. Method of Disposition			Ct; Bal		MD 21234		
Baltimore,	Page 1 nent of l ant: If it		1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, cren	isition (Name of natory or other plac	ce)	Date	20c. Location - 0	lity or To	wn, State
틀	permit. Page Department of Important: If any injury or once.	100	4 N Donation 5 Other (Specify)	1 00			A	hamer Dage	. 3	· .
Ba	Dep Imp any	Į.	21. Six sture a Funeral Service Ucensee Ronald S. June, Dir.	ector				tomy Boar ltimore,		21201
			23a. Part). Enter the disease, or complications that caused	the death. Do not ente						Approximate
- 1	h sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			. 0.55				Interval Between Onset and Death
	Medical		resulting in death)  a.  Due to (or as a	consequence of):	(OCTOR)	/ AFC	25T		+	
	Examiner	<u>_</u>	Sequentially list conditions, b. Acute	Cerebr	OVASC	ular	Accid	ent		
	sit sd	edical Examiner	If any, leading to immediate Due to (or as a cause. Enter Underlying Cause (Disease or iinjury	consequence of):						
	ecute and I-tran	Exal	that initiated events c.	consequence of):	<del></del>		<del></del>		+	<del>-</del>
_	ate be executed physician and the burial-transit	cal		, ,						
2/60	ficate g phy as the		d							
9	endin use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	of pregnancy	Fotonio prognana			23d. Date	of delive	ery
POX	death	Physician/M	1 Yes 2 No 4 Pregnant at 1	time of death 5	Other (specify)			Mont	h	Day Year
7. Ö.	at the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but	+	- 1 - 1 - 1 - 1					
7.	v requires that the death certific been signed by the attending should be detached for use as	l by	Vascular Dement		ndenying cause gi	ven in Part I.		obacco use contrib		
Records,	requir	Completed								ably 4 🗖 Unknown
20	has law	mp	Coronary Artery	Disea.	se		24a. Was auto	psy pri	ere autop or to con ath?	sy findings available npletion of cause of
ב =	n: The ficate or, pag		25. Was case referred to medical				1 Tyes	2 No 1	Yes :	2 🗌 No
N Ed	s certi	To Be	examiner?	nt 2  ER/Outpatien	100	ace of Death (Che				
5	ding Physician: The law h. Affer this certificate has funeral director, page 2 a		27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injun	y at		dence 6 Other		
5	endin sath. or: Aft he fur	lica	1 Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	M 1 🗆	:? Yes 2 □ No				
VISIOII	or Atta	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (S	Street and Number	or Rural I	Route Number,
5	oital o						1			
:	Io the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of exa	amination and/or investi	igation, in my opinic	on, death occurred	at the time date :	and place and due to	o the caus	se(s) and manner stated
	o the within o the ompl	≥ ¦	only one) 3 Certifying Nurse Practioner: To the be 29b. Signature and title of certifier	est of my knowledge, d	29c. License		ace, and due to th	e cause(s) and manr 29d. Date signed (		
			Adman Chon I lan	1				C/ /	_	
		ŀ	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, Pr		0000		1-1	. 0	XUII
		_	Dr. Adnan Choudhury	9000 Fra	aklin Sa	have D	rive Ba	Himore	Mi	21237
	State	_	31. Date filed (Month, Day, Year)  September 1 2 2011	s Signature	Med.					
	Registra		SFP 1 2 2011 Cerus	1 10. 15						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vera R. Duncan-Crosby September 10 2011 a 4:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Days Min Feb. 6 577**-**24-3112 Virginia **Director** 1922 89 1 □ M 2**X** F Usual Residence of Deci 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Florida Oxford Sumter 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5361 Compass Pointe 34484 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) St. John Moffitt Rinker Rulette Virginia Golladay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Duncan III / Son 13-D Ridge Road, Greenbelt, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9/14/2011 4 Donation 5 Other (Specify) Moreland Memorial Park Parkville, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ Dement 2 yeurs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte d be detached for in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death Month Year 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 100 24 hours after deaun.

• Funeral Director: After this certificalletely filled in by the funeral director, i the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitiying Nystem 16 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO070635 MD 9110111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel 701 Charles St 8vite 4105 Baltomare MD 2 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 06-2011

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 1 1 288 16
	Physici */Medi	cal	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year AUGNST 26 Zeil 1c. M2A  4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death
-	Examir Funeral Director	ier	Caton/Manor 3330 Wilkens Ave 2/229 Boltomore Mary land  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) Country)  Months Days Hours Min. (Month, Day, Year) Country)  Usual Residence of Decedent
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and in pipe is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit in pipe in the pipe in the funeral director.	Certification: To Be Completed by Physician/Medical Examiner	23a. Part Enter the displace, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Enail Results of the cause of t
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  A UGUST  27, 2c//
	- 21	ıte.	30. Name and address of person at a commeted cause of death (Item 23a) (Type, Print)  MATERIA AWAN 60796 HICKORY RIDGE RD COLUMBIA MD 21044
	Sta Registi		SEP 1.2 2011 SEP 1.2 2011 Security 9.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

anice Drayton		Sta 1- For State Registrar	ate of Maryla		artment of <i>rtificate of</i>		nd Mental		201 eg. No.	1 2881
Physicia Medical Exami		Decedent's Name (First, Middle						2. Date of Dea Month Septembe	th Day Year	3. Time of Death
1		Janice Drayt  4a. Facility Name (if not institution	on n, give street and num	nber)	4	• • • • • • • • • • • • • • • • • • • •	or Location of De		4c. County of Dea	
Funeral		University Hospital  5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	Baltimore If Under 1 Ye	ear If Under 24	Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. E	
Director		217-76-4377	1 M 2 X F		51 <sub>Yrs.</sub>	Months Da	ys Hours	Min. 8/24	/1960 For	eign Country) MD
kue		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locatio	n				10d. Inside City Limits
<b>*</b>	ō	MD N/A		Bal	timore					1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 911 Leadenhal	l St. Ap	t. G5		10f. Zip Code 212	30	1	0g. Citizen of What Co	ountry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28s-f she mastic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Mar		edent Ever in U			lispanic Origin? an, Mexican, Pu	( Specify Yes or No erto Rican, etc.)	o- 14. Race - Am White, etc.	erican Indian, Black,
after dea	by Fur		1 Yes	2 X No	1 🗆	Yes 2 X N	o specify:		Specify: B1	ack
hours a	ted b	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade				ation (Give kind e. DO NOT use		16b, Kind of Busines	s/Industry
036 vithin 72 ene. er than	Completed	12th	2 yrs.	4010.7	Disa	abled			N/A	
21215-0036 Juld be filed within 72 hours at IMental Hygiene. marked other than "natural ic event, the Medical Examin	Be C	17. Father's Name (First, Middle, I John Drayton	_ast)					ame (First, Middle, I Jean G		
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than umatic event, the <u>Medica</u>	의	19a. Informant's Name/Relationsh	ip(Type,Print) . <b>etc</b> . <b>coll</b> —Sis	tor					nber, City or Town, Sta	
and and tent		20a. Method of Disposition		20b.	Place of Disposit	ion (Name of ce	emetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other Spe	ecify:	Du.	laney V	alley			Timonium	
Ball permit Depart Impor	Į	21. Signature of Funeral Service L Brown Milliam				me and Addres		March F , MD 21	/H 1101 E 202	E. North
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	omplications that car	used the death	. Do not enter the	e mode of dying	g, such as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Asphyxia  Due to (or as a c	consequence o	f):					Death
	-	Sequentially list conditions, if any, leading to immediate	b	consequence o	f):					0
_	Examiner	cause. Enter Underlying Cause (Die asso or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence o	f):					
60, tte be executed hysician and e burial - transit			d	10h nor	- fb c01	0 0_27	11			
60, ate be ex hysician	Medical	UNPENDED  IF FEMALE:	23c. If ves. or			9 9-21-	-11 VC		23d. Date of delive	Dry
Box 6876  e death certificate the attending phy ed for use as the l	cian/l	23b. Was decedent pregnant in the past 12 months?	1 Live bir		2 Feta	I death 3 er (Specify)	Ectopic pre	gnancy	Month	Day Year
. BO)	Physician/N	1 Yes 2 ✓ No 9 Unkn  Part II. Other significant conditio	9 UNKNOV		esulting in the un		given in Bort I	220 Did to	bacco use contribute t	o the cause of death?
P.C	হ	Tarrii. Other significant condition	Tie Contributing to		esulting in the un	derlying cause	given in Fait i,		s 2 ✓ No 3 Pr	
Vital Records, sysician: The law require this certificate has been sidirector, page 2 should be	Completed							24a. Was autop	sy prior to	autopsy findings available completion of cause of
tal Rec		25. Was case referred to medical	1			26 Plac	e of Death (Che	1 Yes		
1 of Vital Rec ling Physician: The I After this certificate b funeral director, page	8 2	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		TO#===		Residence 6 Oth	er:
nding Pl nding Pl th. r: After		27. Manner of Death  1 Natural 5 Pendir	28a. Date o (Month, I Sep 1, 20	f Injury Day,Year) 111	28b. Time of Inj 1254 hrs	· 1	ury at Work? Yes 2 ✔ No	28d. Describe t Subject cho	now injury occurred ked	
Division tal or Attendi rs after death. al Director: /	Certification	2 Accident Investi 3 Suicide 6 Could	not be 28e, Place	of Injury - At ho	ome, farm, street,	factory, office	building, etc.	28f. Location (S		tural Route Number, City
Divis  To the Hospital or A within 24 hours after to the Funeral Dire completely filled in		4 Homicide determ  29a. Certifier 1 CertifyIng Phy	(Opcomy)	Multi-Famil	<u> </u>	ed at the time, d	date and place	911 Leadenha	all Street, Baltimore, e(s) and manner as sta	
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Exam		examination a		n, in my opinio	n, death occurre		and place, and due to	the cause(s)
	2	29b Signature and title of certifier	2000	1/20	50	29c. Licens	se number .M.E.		29d. Date signed (M September 2, 2	
		30. Name and address of person w			•	Dalkier (	Direct D. W.	- AD 040	1	
Sta	ite	Victor Weedn MD JD  31. Date filed (Month, Day, Year)		ical Examir			street, Baltir	nore, MD 2122	:3	
Registr	_		2017 Cen	our 1	9. par	The second				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 21 per DVR G919 9/12/11 dk
State of Maryland / Department of Health and Mental Hygiene For State 28818 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month q US Physician/ 14 20) AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and nu 4b. City, Town, on Location of Death Examiner Raltimore HUSP Randallstown of thruses + If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Min Country) 1 □ M 2 😿 F Hours May 28, 1947 216-52-9165 64 Yrs Ohio Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland Medical Examiner must be notified at Director 1 Yes 2 X No MD **Baltimore** Pikesville 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? or items 23a Funeral 1305 Greenbriar Circle 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. other than " Social Security Admin. College (1-4 or 5+) Elementary/Seconday (0-12) Training traumatic event, the Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental F 27 is marked o ၉ Cecelia Theresa O'Konski John Thomas Daley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is Charles Lewis 15 Helms Pick Court, Catonsville, MD 21228 other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State ò Department or Important: If any injury or Ardent Cremation, Inc. 08/16/2011 Hanover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. . Signature of Funeral Service Licensee Michael P. Marzullo per DVR Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 mon Month Day Year Pregnant at time of death Yes 2 UNO be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? To the Hospital or Attending Physician: The within 24 hours after death, To the Funeral Director: After this certificate I Yes 2 No 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural injury 5 Pending 2 Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one 29d. Date signed (Month, Day, Year) 29b. Signatur and title o certifie 29c. License number 00062650 20 person who completed cause of death (Item 23a) (Type, Print) Road RandallStown naini (out lanvee 401 DIC 31. Date filed (Month. strar's Signature State Registrar

30

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				rtment of Health and tificate of Death	Mental Hygier Reg. N		28819
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Lonnie Augustus Decatur		2. Date of Death Month E Sept. 8, 2	Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number)  LOCH RAVEN VA CLRC	4b. City, Town, or Location of Death Ballimore		4c. County of Death	13-51
	Funeral Director		5. Social Security Number 218-28-6850 6. Sex 1 M 2□ F 7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 5,1	9. Birthp Coun	
	Maryland -f show	tor	Usual Residence of Decedent			11/	0d. Inside City Limits 1 XYes 2 ☐ No
	th with the 23a or 28a ust be noti	<b>Funeral Director</b>	10e. Street and Number 1030 E.33rd St.Apt.113	10f. Zip Code 21218	10g. (	Citizen of What Coun	itry?
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show digal Examiner must be notified at	þ	Never Married 2 Married 1 Seven Seven Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decede	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert Yes 2 No Specify:	16b.	14. Race - Americ Black, White, e Specify: Bla Kind of Business/Ind	etc. ck
2121	l within giene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) (Give ki	nd of work done during most of word NOT use retired)	king	ppers Co	·
Maryland	ges 1 and 2 should be filled int of Health and Mental Hygir! If item 27 is marked other or other traumatic event, It	To Be (	17. Father's Name (First, Middle, Last)  Lonnie Decatur		ne (First, Middle, Maide		
	and 2 sho ealth and n 27 is ma		Barbara Joan Flowers (niece) 2	Address (Street and Number or Ru Hazy Morn Ct. A			
Baltimore,	permit. Pages 1 al Department of Hee Important: If item any injury or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposicemetery, crema Garrison	for (Name of tory or other place) Forest Vetera	. 1 <i>1</i> วก11	Location - City or Town	
Bal	permit Depar Impor any in			Name and Address of Facility Blvin B. Scruc 412 E. Prestor	ı St. Bal	al Home to,Md. 2	1213
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a connequence of):	the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	tificate be executed SS graphsician and as the burial-transit at	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Each of underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):				
P.O. Box 68	ath cer attendir or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ B	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
rds, F	requires that the de been signed by the a should be detached f	ed by P	Part II. <b>Other significant conditions</b> contributing to death but not resulting in the under Small Bowel Obstycction	erlying cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death? ably 4 ☐ Unknown
_		Completed by	STROKE		24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
of Vita	Physician: he this certificate al director, page	Be	25. Was case referred to medical examiner?  1  Yes 2 No	3 ☐ DOA Other: 4 Nursing Ho	h (Check only one) ome 5 \sum Residence	6 ☐ Other (Specify	
Division of Vital	the rospital or Attending Physician: hin 24 hours after death.  the Funeral Director: After this certifics mpletely filled in by the funeral director, p	Certification: To	27. Manner of Death  1 Natural  2 Accident investigation  3 Suicide 4 Homicide  4 Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  28b	28c. Injury at Work?  M 1 □ Yes 2 □ No , factory, office	28d. Describe how inju 28f. Location (Street a City or Town, Stat	and Number or Rural	Route Number,
:	vithin 24 hours To the Funeral completely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause( red at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
,	no me within 2 To the Complex	¥	29b. Signature and title of certifier  M · D	29c. License number  0.56508		ate signed (Month, D	
1	<b>/</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	D56508 NAMERON Baltimore	16, 91 m D	212/0	ß
	Stat	e	31. Date filed (Month, Day, Year)  32. Replace's Signature				

DHMH 17 Rev 1/2001

DECATUR, LONNIE

amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Day **Physician** Year 2145 M GEORGE HENRY DRURY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 517 AVIRETT AVENUE UMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. ate of Birth Month, Day, Year)
9. Birthplace (State or Foreign Country)
01-05-1955 District of Columbia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 218-68-428 1**⊠**M 2□F Months Days Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits ? Is marked other than "natural", or items 23a or 28a-f sho traumatic event, I've Medical Examinar is ust be notfibed at Director 1 ☐ Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 517 21502 Funeral 11. Marital Status unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 X No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 white If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No <u>ک</u> Specify: 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 laborer draperies manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George H. Drury III ELizabeth J. Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Holly Ave; LaVale, MD 21502 Jack Drury - brother Department of Health Important: If item 27 any injury or other troops. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Funeral Serv 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Metastatic **Physician** 3 month /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abuserian and as the burial-trans and resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown p signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page 2 this certificate 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) nours after death.

neral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and tibe of certifier 29d. Date signed (Month, Day, Year) ress of person with completed cause of death (Item 23a) (Type, Print) Starting CRNP 1050 Fudus d address of pers 1050 Industrial Blvd Combelland 31. Date filed (Month, Day, Year) 32. Registrar's Sign Iture State 2011

Registrar

Please Type or Print in Black Indelibe Ink. Ensure All Copies Are Legible.

#20b Per FH G9 in Black Indelibe Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28821 Reg. N2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical nn MOVE OO & M OI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 050 7. Age (In yrs. lat birthday)
Yrs. DYC If Under Funeral 8. Date of Birth (Month, Day, Ye If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🖫 F Months Days Min. Hours Country Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No t7 m 10e. Street and Number 10g. Citizen of What Country? 23a items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced If Yes, Give Year or Dates 2 No Specify. "natural", Blac permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Ms. Filbert's life. DO NOI Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna ne) မ 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21223 Baltimore S 20a. Method of Disposition 20b. Place of Disposition (Name of 9/08/2011 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of In al Service License 22 Name and Address of Facility reral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Demon Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated secrets) Examine Due to (or as a consequence of): and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Unknown Month Dav Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ¥ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 🗷 No ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/α investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO 431,427 000 2210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) )true 31. Date filed (Month, Day, Year) State 2. Registrar's Signature 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gary Richard Farrell Sr. 8:23PM Medical . Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death pice lisbu Sa Comico If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 X M 2 □ F Davs Nov 22 Hours Director Maryland 214-66-8197 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f MD Wicomico Delmar 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 9235 Clare Cir 21875 IISA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married ö à Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white "natural" Completed 3 Divorced 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) warehouse laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental F ပ Mary Frances Harrison John Robert Farrell 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 9235 Clare Cir; Delmar, Maryland 21875 Denise A. Farrell - wife Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place any injury or 21. Signature Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board actor 655 W. Baltimore St; Baltimore, MD 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas , or complications that caused shock, in leart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter oncernying Cause (Disease or iinjury Due to (or as a consequence of): ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregna
☐ Pregnant at time of death 5 ☐ Other (specify) 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARIS

v

Ba

gistrar's Signatu

			For State	State of Ma	aryland /				nd Mental H	ygien	e			
		_	Registrar Certificate of Death Reg. No.							100	<u> </u>	20023		
Phys										ır <sub>1</sub>	3. Time of Death 12:10 A <sub>M</sub>			
	edic ımin		Wilbur Dull Fult  4a. Facility Name (if not institution, give s				# 01 T	Ib. City, Town, or Location of Death					12:10 AM	
		er	Carroll Lutheran	· · · · · · · · · · · · · · · · · · ·			Westm:	eath	4c. County					
Fune	eral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda				If Under 1 Year	Hrs. 8. Date of E	Birth	9. Birthplace (State or Foreign				
Direc	tor		243-09-5171	]M 2□F	93	Yrs.	Months Days	Hours N	Min. (Month, L April	Day, Year,	1918	USA		
Mot wot	4	١	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Location									
arylar a-f st	nen i	cto		Westminster							10d. Inside City I			
he Mi			MD Carrol1  10e. Street and Number		10f. Zip Code			10			g. Citizen of What Country?		1 🗆 Yes 2 🖾 No	
h with t	nen i	Funeral Director	205 St. Mark Way	Apt 226	5 21158					Tog. (	USA			
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 28a or 28a-f show training event the Marinal Eventuals.	T Pygillies	ē	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ev Armed Forces? 1 A Yes 2 N If Yes, Give Year or Dates.	10/0	1942 If Yes, specify Cu			Hispanic Origin? (Specify Yes or No- pan, Mexican, Puerto Rican, etc.)  Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
2 ho	anic I	ple	15. Decedent's Edu (Specify only highest grad	16a.	Deced	ent's Usual Occupa				b. Kind of Business Industry				
ithin 7 than than		Completed	Elementary/Seconday (0-12)	-)	life. DC	NOT use retired) sineer				AT&T				
IC 2		Be (	17. Father's Name (First, Middle, Last)				,	18 Mother's	Name (First Middle					
Marylanc  2 should be file h and Mental H 7 is marked o		욛	Thomas Pinkney Fulton				Nannie 1			(First, Middle, Maiden Surname) Martin				
Mar 12 shou 1th and 27 is m			19a. Informant's Name/Relationship (Typ Pearl Fulton - v	*	19b		g Address (Street a							
baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other			20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 ☒ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Total Cemetery, crematory or other place)								or Towr	n, State		
permit Depart Import	once.		21. Signature Funeral Service Scenses Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201											
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate											
Physicia			Immediate Cause (Final disease or condition CALCANANCE Onset and Death											
Medic Examir			resulting in death)	Due to (or as a	conseque ce c	ıf):	0-	putio	,					
p #	7	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  CHECK OF THE UNDERLY CONSTRUCTION OF THE UNITY OF THE UNIT							-0				
execute n and al-tran		EXa	Cause (Disease or iinjury that initiated events c resulting in death) Last	f):	obstructive fulmonary 0				Stast					
ox oo rou arth certificate be executed attending physician and for use as the burial-transit		agica		Communic	e. Ting 1	tydi	eoce tho	105						
ertific ding p			F FEMALE:	c. If yes, outcome of	pregnancy							•		
Attending Physician: The law requires that the death certific are death.  **Attending Physician: The law requires that the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as		Physician/IN	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year						
requires that been signed should be det		2	Part II. Other significant conditions conf	ributing to death but	not resulting in	the un	derlying cause give	n in Part I.			use contribute		cause of death?	
The law recate has be page 2 sh		Completed							24a. Was auto perf 1 \subseteq Yes	opsy ormed?	prior to death?	comp	findings available eletion of cause of	
Physician: The this certificate al director, pag	ď	ا ۵	5. Was case referred to medical examiner?	spital:					heck only one)					
Phys r this		2 2	1 ☐ Yes 2 🔀 No Pro	1 Inpatien 28a. Date of injury	t 2 ☐ ER/Out 28b. Ti			4 Nursing	g Home 5 Resi			ecify)		
r Attending F re death. rector: After		Sate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, )		jury	28c. Injury a work? M 1 🗆 Y	es 2 □ No	28d. Describe	how inju	ry occurred			
ital or Atterns after de al Directo			3 Suicide 6 Could not be 4 Homicide determined	y - At home, farm, street, factory, office Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fi	Modification		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To with Con-		2	9b. Signature and title of certifier  R, E, Wa/a	land,			29c. License r	number 7 154		29d. Da	ate signed (Mon $8/66/2$	th, Day	(, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  R. E. Walden 300 ST, Luke Circle Westminster											Md. 21/58			
S Regis	tate strar	3	31. Date filed (Month Day Year) 32 flegistrat's Signature											
					6	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 28824 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Robert 03:31 Fitzpatrick September 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Bultimore 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 942 Virginia 68 Director 190-34-5151 Nov. Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location **Funeral Director** an "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 XYes 2 No Columbia Howard Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21044 10340 Swift Stream Place Apt. 109 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner musquoce. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married 1 A Yes 2 1960 If Yes, Give Year or Dates 1987 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) American Vision Center Optician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary C. Hamilton Peter J. Fitzpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10340 Swift Stream Place Apt. 109 Columbia, MD 21044 Ginger Fitzpatrick/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 9/11/2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Fleck Funeral Home 22. Name and Address of Facility Signature of Funeral 7601 Sandy Spring Rd. Laurel, MD 20707 MO123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Myelotibrosis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Coronary Artery Disease 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ischemic Cardiomyopat has autopsy perform Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 🖃 No Other: Certificate: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral iniury 5 Pending 2 🗌 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h. Signature and title of certi 29c. License number MD September 8,2011 D72527 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St., Baltimore, MD Phelan 31. Date filed (Month, Day) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris J. Foor 09 3:50 4M Medical 4a. Facility Name (if not institution, give street and num Examiner wn, or Location of Death 4c. County of Death n/a AGNES altimare Social Security Number 1 Year If Under 24 Hrs. **Funeral** Age (In yrs, last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2🗶 F 165-24-6312 Months Days **Director** 107/307/1929 81 Pennsylvania Usual Residence of Decedent show 10a State with the Maryland Director 10b County must be notified at 10c. City, Town or Location 10d. Inside City Limits 28a-f Halethorpe MD Baltimore 1 Tyes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5108 South Street 21227 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu ence. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 X Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Dietary Aid State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lozenzo Newton Ritchey Nellie Mae Stayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Foor / Son 2040 Putnam Road, Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 9/13/2011 Baltimore, Maryland nat e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 ANo
9 Unknown Pregnant at time of death Dav signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? perfori Yes hours after death.

Ineral Director: After this certific
d filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ည 1 🗌 Yes Other: 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month, Day, Year) 5 Pending Investigation 1 Tes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled the Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, a 2th annumed at the time, date of place, and due to the cause(s) and manner stated. (Check only an 29b. Signatu ULLA leath (Item 23a) (Type, Print)

/ DHMH 17 Rev 7/2009

State

Registrar

0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) FETTEMBEL Physician/ Ethe1 Fedak Medical 4c. County of Deal 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner GUEN BURNIE BACTIMORE WOCHINGTON MEDILAL VER Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number December 23, 1919 **Funeral** Hours 1 🗆 M 2 🛛 F Months Pennsylvania 91 579-40-2202 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No Annapolis Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 21401 Funeral 800 Midship Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygleine. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, <u>the Medical Examiner mu</u> 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No þ White 1 Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore, Maryland 212 Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary Siwlveosoe မ Joseph Bontya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8154 Quarterfield Farms Drive, Severn, MD 21144 Kathleen Ann Bridgers/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place)
West Arundel
Crematory Date 20a. Method of Disposition September 11 2011 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Odenton, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licensee Will & Bouen M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death YASCULAR Immediate Cause (Final 15RO Physician/ disease or condition resulting in death) Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Completed by 4 Unknown 1 Yes 2 No 3 Probably page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 1 Yes 2 No Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: funeral director, Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ၉ 28b. Time of 28d. Describe how injury occurred 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 2 Acciden
3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature 2011 U (Item 23a) (Type, Print) cause of death address of person who completed 301

State Registrar 31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(evin Fowlkes			8827
Physicia Viedical Exami		1. Decedent's Name (First, Middle, Last)  2. Date of Death Anoth Anoth Anoth	of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5217 Fredcrest Road  Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	itate or
Maryland 28a-f show any d at once.	or	MA	de City Limits
death with the Maryland or items 23a or 28a-f sho must be notified at once.	al Director		Riad
urs after death w ttural", or items	by Funeral	3 Widowed 4 Divorced in res, Give rear 1 Yes 2 No specify: Specify: Specify:	, Diaux,
36 thin 72 hc te. than "na edical Ex	Completed		
121 Id be fil Mental I	o Be Co	Alphonzo Fowlkes Relle Mitchell	2)
MD and 2 shot and		Andre A. Fow Kes Brother 5200 Hillwell Kg. Raltimore, MD 212  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Dete, 20c. Location - City or Town, Sta	129
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other to	į	A Donation 5 Other Specify:  2 Sign ture of Funeral Se /i Licensee)  2 Name and Address of Facility  2 Name and Address of Facility	1 <u>)</u>
Physician	-1		1259 imate Interval en Onset and
/Medical			Death
	miner	Sequentially list conditions b.	**************************************
executed an and al - transit	Exa	events resulting in death) Last Due to (or as a consequence of):	
be co	edical		
Division of Vital Records, P.O. Box 68760.  Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.  Funeral Director: After this certificate has been signed by the attending phystely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
res that the d signed by the detached	by Ph	- VV- 2 TV- 2 T Purkey, 45	-
of Vital Records, P.O ng Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detacted.	Completed	Chronic Alcoholism, Hypertensive Atherosclerotic  Cardiovascular Disease  Cardiovascular Disease  24a. Was an autopsy find prior to completion death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes	ngs available
tal Rectan: The	B	25. Was case referred to medical examiner?	
ing Physi Ling Physi After this funeral dir	P	1 Nursing Home 5 Residence 6 Other: Scene	
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	Natural   2   Accident   Accident   Accident   Accident   Accident   Accident   Suicide   Accident   Acciden	
Divis  To the Hospital or ≠ within 24 hours after To the Funeral Dire completely filled in b	Medical C		
5 4 5 4	M	Theology Mr. King Thy Mind O.C.M.E. OCME September 8, 2011	ear)
^		30. Name and address of person who completed clause of death (frem 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta Regist	-		

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28828 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2011  $A^{M}$ Ralph Coolidge Gorman August 7:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10208 Mar Rock Dr. Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 31, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. 219-14-8292 Director 88 1923 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinational be restitled at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10208 Mar Rock Dr. 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 43-46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates: 1 ☐ Yes 2 X No δ Specify: Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, 112, 900.8. correctional officer law enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Gorman Mary Jane Keiffer ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10208 Mar Rock Dr; Hagerstown, MD 21740 Mary Ann Gorman - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signatur Funeral ervice Licensee Rorald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 rt1. Enter the disease, or complications that caused th ock, or heart failure. List only one cause on e.c. ine. Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedian Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a.i.y, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) the detached 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 1 □ Yes 1 ☐ Yes 2 ☐ No 2 **N**0 the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \text{ Residence} 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 X No Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number D0063718 Name an Taddress of p 11110 medic no completed cause of death (Item 23a) (Type, Print) M.D 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#IperpHYS, G919, 9/22/2011, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Lewis Godsey Jr 2 Date of Death Month Day 17:16 PM Physician/ Medical Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner 4c. County of Death 0 Ratti JOHNS HOPK INS more If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign rs. last birthday) Funeral (Month, Day, Days Min 1 X M 2 🗆 F Months Hours Yrs Director MD 215-11-6324 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Parkville 28a-f MD Baltimore 1 Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r U.S.A. Funeral 21234 8320 Kendale Road death v items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Xvever Married 2 Married o, þ Page 1 and 2 should be flied within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced Black Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Disabled Disabled grade na of Health and Mental Hygi item 27 is marked other other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Dixon Lewis Leon Godsey Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8320 Kendale Road, Parkville, Md 21234 19a. Informant's Name/Relationship (Type, Print) Minnie Godsey-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or once, ö Memorial Park 9/10/2011 Woodlawn, Md 21. Signature of Fureral Service Licensee 22. Name and Address of Facilit March F/H Wes 4300 Wabash West Baltimore, 21215 Ave. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Decompensate Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a contequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 9 Unknown been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\subseteq\) Nursing Home 5 \(\supseteq\) Residence 6 \(\supseteq\) Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. injury မ After this 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 💢 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature e o certifie North Wolfe St, Ta egistrar's Signatu State 0 9 2011 Registrar

Baltimore, Maryland 21215-0036 Box 68760 P.O. Records, **Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28830 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Aruc 0913 On Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice at Northwest Hospital Randallstown 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 229-44-0418 Director 1 X M 2 □ F oct 25, 1937 Virginia 73 Usual Residence of Deceden 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 1012 Pennsylvania Ave; Apt 104 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, <u>the Medical Examiner</u> I Black, White, etc 1 Never Married 2 Married p Specify: black 1 ☐ Yes 2 X No Specify 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) laborer meat packing plant Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ Fletcher C. Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Greene - daughter PO Box 676; Windsor, Virginia 23487 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) in State Signature of Five Halle Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Gallbladder Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the t nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 Yes 2 XNo ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier asky opedniM1) DOOS7465

State Registrar N. S. Kujapaksemi) 2875 5 min / N. 31. Date filed (Month, Day, Year) S. Registrar's Signature for the state of the state o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5.03 Baltimore MD 21706,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 8 2011 Physician/ 1:00 Рм Janice May Galiani September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium 2124 Fountain Hill Dr. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Hours 212-38-4673 **Director** 71. 1940 Mary Land 1 🗆 M 2 🗶 F Aug. Usual Residence of Decedent 28a-f show 10a. State event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Maryland Timonium 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2124 Fountain Hill Dr. 21093 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ŏ Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 'natural", 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Nursing and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick Reichert Edith Hofsass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Alex Galiani - Son 240 Stevenson Lane Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial ② Cremation 3 ☐ Removal from State HilltopServiceCorporation | 9/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Fune 11 Service Lien 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OCC disease or condition rocers Medical resulting in death) **Examiner** ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine ean and burial-trai resulting in death) Last physician Physician/Medical The law requires that the death certificate be eurs P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) be detached for in the past 12 months? Day Pregnant at time of death 9 Unknown Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pag ma 1 Tyes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🙋 No 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 🗹 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Modical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check etifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month)

2 Ham II Rd Suite 222 Baltenere 21210

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janet Grim 028 PM September 2011 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Baltimore N/A baltimore 8. Date of Birth
(Month, Day, Year)
Sept. 12 1940 9. Birthplace (State or Foreign **Funeral** 208-32-1091 Pennsylvania **Director** 1 - M 2 X F 70 ms 23a or 28a-f show must be notified at 10h Count 10c. City, Town or Location 10d. Inside City Limits Funeral Director Mary land N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 305 Cable Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married 2 Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4 or 5+) Education Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Mary Dougherty Benjamin Kinsey Grim, Jr. 19a. Informant's Name/Relationship (Type, Prin Religious Sr. Kathleen O'Brien Sister Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CableStreet Baltimore, Maryland 21210 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Hill top Service Corporation Towson, Maryland 9/15/2011 4 Donation 5 Other (Specify) any in once. 21. Signature of Funeral Scense 22. Name and Address of Facility Ruck TowsonFuneral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and De. t Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy jo Month Year Dav Pregnant at time of death 5 Other (specify) the g Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Hospital or Attending Physician: The 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Pesidence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Natural 5 Pending (Month, Day, Year) work? 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D63202 se of death (Item 23a) (Type, Print) Sinai Hospital of Ba State Registrar DHMH 17 Rev 06-2011

11-06661 Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ryan D. Henry Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 0203 Dath's Day Medical Examiner Dandre September 4, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 6. Sex If Under 24Hrs. 9. Birthplace (State or Foreign KW **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) Months Days Director Hours Min 25 146-80-4246 1 M 4-12-1986 Country) 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a nr 28a-f show 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked nither than "natural", nr items 23a nr 28a-f sho New Jarsa leanick Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5% 1145 U.S.A. 07666 Funeral Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married White, etc. 2 Married 2 X No Yes Yes 2 No specify: 3 Widowed If Yes, Give Year traumatic event, the Medical Examiner 4 Divorced Specify: Black <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 17. Father's Name (First, Middle, Last) Be /tenry a.k.a Donald Henry 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54. 145 Stasia Teaneck 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, 20c. Location - City or Town, State or other crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I -17-2011 Donation 5 Other Specify permit. ig ure of Funeral Service Lice **Physician** Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval failure. List only one cause on each I Between Onset and /Medical a. Gunshot Wound of Chest Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED#3perME,G919,9/22/2011,WS UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was en 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? ✔ Yes 2 No 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) director, Be examiner? Other Nursing Home 5 Residence 6 Other: 2 1 🗸 Yes After 28a. Date of Injury (Month, Day,Year) Sep 4, 2011 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural 0000 hrs death. Pendina 1 Yes 2 V No Director: fill d in by the 2 Accident Investigation 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) Mineral, WV. To the Hospit - c determined (Specify) Local Street To the Funeral 4 V Homicide 29a. Certifier 1 (Check only 1 one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. September 4, 2011 NI me and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State **OCME** Registrar Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Roselyn Elizabeth Brown Hammond 2011 03:50 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) 72 436-70-2204 1 □ M 2 🏝 F Yrs. 39 LA 01 01 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA MD 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21215 3502 North Hilton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Morgan State College (1-4 or 5+) 8 **yrs** Elementary/Secondary (0-12) Professor of Biology 12th grade University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alma Farrar Robert Brown Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21215 3502 North Hilton Road, Baltimore, Dr. Ernest Hammond-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 9/13/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West Funeral Service Licenses van Baltimore, Md 4300 Wabash ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter 🛰 mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day Month Year Pregnant at time of death 9 Unknown ert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopu, performedic death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cother (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred

certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Division of Vital Records, filled in by the funeral director, this s after death. I Director: After t Hospital 24 hours within 24 hor To the Fune completely fi

**Funeral** 

**Director** 

Health and Mental Hygiene. tem 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner.

permit. Page 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event; the Medical Examinone.

Physician/

Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland ms 23a or 28a-f sho must be notified at

> 28a. Date of injury (Month, Day, Year) Natural work?
> 1 Yes 2 No injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check one) onl 29b. Sigi 29d. Date signed (Month, Day, Year) 0071287

> > Suite 4105, Balthaure, MD 21204

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28835 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mrain 2011 22:55P<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3402 Holmes Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Month, Day, 1**X** M 2 □ F Director 220-20-672 83 Usual Residence of Deceden show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director X Yes 2 No MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be Funeral 3402 Holmes Avenue 21217 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. African ģ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American Completed 3 Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Southern State Elementary/Seconday (0-12) College (1-4 or 5+) Fertilizer Corp. 6th Grade Industrial Mechanic NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ephraim W. Hobbs, Sr. Ellen Mosbey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,21217$ 19a. Informant's Name/Relationship (Type, Print) Vivian Nancy Hobbs-Wife 3402 Holmes Avenue Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Garrison Forest 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 09-12-11 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses any 38 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examine Sequentially list conditions if any, keeing to immediate cause. Enter Underlying Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tyes ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work?
1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

2103

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Idel1 03 201 Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Alice Manor Nursing Home NA <u>Baltimore</u> Social Security Number 6. Sex If Under If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Year Days Hours 1 - M 2 X SC **Director** 216-34-6197 76 0 Usual Residence of Decedent ral", or Items 23a or 28a-f show Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2095 Rockrose Avenue 21211 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: American Completed 3X☐ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "naturany Injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 9th Grade College (1-4 or 5+) Housekeeping Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Jackson Lugene Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 McElderry Street Baltimore, MD 21205 Rosa Lee Strong-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State 09-09-11 Lansdowne, MD 4 Donation 5 Other (Specify) Mt. Zion Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Gilmor Street Ν. Baltimore.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. thero Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Dav Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy perform 2 100 Yes 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ♠No Hospital Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Euten ST. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of M			tificate of L			Reg. No		28837		
	Physicia		Decedent's Name (First,	, Middle, Last	t) Bertha	Elle	n Hano	ce		Month	2. Date of Death Month Day Year September 6, 2011 5:04 A				
	Medic Examin		4a. Facility Name (if not ins	stitution, give				4b. City, Town, or	Location of De			. County of Deat			
مرب	Function		Gilchrist Center Columbia  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24 Hrs						lrs. 8. Date of Bi		Howard	thplace (State or Foreign			
	Funeral Director		217-24-488 Usual Residence of Deced	17-24-4883								8 Mai	untry) ryland		
	land f show d at	tor		County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
	Mary 28a-	irec		taffor	d	Sta	fford					1 X Yes 2 No			
	ith the	ral	10e. Street and Number					10f. Zip Code				tizen of What Co	ountry?		
	ems 2	<b>Funeral Director</b>	5 Old Mine:	ral Ro	ad 12. Was Decedent B	ever in U.S.	13. V	22554 Vas Decedent of Hi	ispanic Origin?	(Specify Yes or No		S.A. 14. Race - Ame	rican Indian		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ 3 【☑ Widowed 4 ☐ Di		Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.		l I	f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		Black, White	e, etc.		
2-0	2 hours "natur dical I	plete	15. D	Decedent's Ed				lent's Usual Occup		vorking	16b. K	(ind of Business			
Maryland 21215-0036	ithin 72 ene. • than '	Completed	Elementary/Seconday (		College (1-4 or 5	i+)	life. Do	O NOT use retired)	iuring most or vi	rorking		n Home			
5	iled w I Hygi other	Be	17. Father's Name (First, M	fiddle, Last)			nomen	liaker	18. Mother's N	lame (First, Middle					
ylar	ld be f Menta arked atic ev	잍	Harry Gavi	gan					Maggi	e Grimes					
Mar	shou h and 7 is m traum	19	19a. Informant's Name/Re					ng Address (Street a							
	and 2 Healt tem 2	23	Elizabeth 3		on / daugh			d Minera	l Road,	Staffor		irginia ocation - City or			
Baltimore,	Page 1 ment of ant: If i ury or		1 ☐ Burial 2 🗶 Crer 4 ☐ Donation 5 ☐ C			cer	metery, cren	natory or other place del Crema					Maryland		
Balt	permit. Departr Import any inji		21. Signature of Furieral Se	evice Lice se	7/	M007	22 I	Name and Addres	ss of Facility Funera	l Home,	P. I	ć:	0707-4389		
Ţ			23a. Part 1. Enter the dise shock, or heart ipilure	ase, or comp	lications that caused e cause on each line	the death.							Approximate Interval Between		
	Ph_sician/	3 13	Immediate Cause (Final disease or condition		11.0				1 1 1	131					
	Medical			-	a	FRAL	THE	£	141	MY			Onset and Death DAYS		
	Medical Examiner		resulting in death)	ſ	a		,	<i>E</i>	MM	W	$\overline{/}$		DAYS		
and the second	Examiner	niner	resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying	te	b. <u>DS7F</u> Due to (or as a	O P O	ROSE			A DEBRIVED BY MEDI	CAL EXAM	mer	DAYS		
and the second	Examiner	Examiner	resulting in death)  Sequentially list conditions of any, leading to minimize the	te	DSTE	OFO conseque du S	ROSE			APPROVED BY MEDI	CAL EXAM	men and			
09.	Examiner  hysician and  the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	te	b. DSTE	OFO conseque du S	ROSE			APPROVED BY MEDI	CAL EXAMI	INER	DAYS		
	Examiner be executed by physician and sthe burial-transit	ledical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	te C	b. Due to (or as a d	OF CP a conseque MYS a conseque	ROSE since oil.		CERTIFICATION	APPROVED BY MEDI	Ī		DAYS YEARS YEARS		
Box 68	death certificate be executed  ne attending physician and ed for use as the burial-transit	ledical	resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	ant 2	b. Due to (or as a d.	CONSEQUE  A CONSEQUE  of pregnance  Fetal (	ROSIS since oil. SEMA since of):		CERTIFICATION	APPROVED BY MEDI	Ī	23d. Date of del Month	DAYS YEARS YEARS		
P.O. Box 68	at the death certificate be executed  by the attending physician and etached for use as the burial-transit	Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregna in the past 12 months:  1	ant 2	b. Due to (or as a d. Due to (or	of pregnance 2 Fetal at time of de	ROSIS	Ectopic pregnanc	CERTIFICATION	23e. Did	tobacco t	23d. Date of del Month use contribute to	DAUS  YEARS  livery Day Year  the cause of death?		
P.O. Box 68	at the death certificate be executed  by the attending physician and etached for use as the burial-transit	Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregna in the past 12 months' 1  Yes 2 No 9  Unknown  Part II. Other significant of	ant 2	b. Due to (or as a d. Due to (or	of pregnance 2 Fetal 4 time of de	ROSIS	Ectopic pregnanc	CERTIFICATION	23e. Did 1	tobacco u	23d. Date of del Month  use contribute to	DAYS  iJEANS  Ivery Day Year  of the cause of death?  robably 4 □ Unknown		
P.O. Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	ant 2 conditions con	b. Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due	of pregnance 2 Fetal 4 time of de	ROSIS	Ectopic pregnanc	CERTIFICATION	23e. Did 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Yes 2 an appsy	23d. Date of del Month  Use contribute to  No 3 Pr  24b. Were au prior to c death?	DAYS  IYEARS  VERY Day Year  The cause of death?  Trobably 4 Unknown  Tropsy findings available completion of cause of		
Records, P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	enditions con	b. Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due	of pregnance 2 Fetal 4 time of de	ROSIS	Ectopic pregnanc Other (specify) nderlying cause glv	CERTIFICATION	23e. Did: 1 24a. Was auto perf 1	Yes 2 an appsy	23d. Date of del Month  Use contribute to  No 3 Pr  24b. Were au prior to c death?	DAYS  IJEARS  JEARS  Ilivery Day Year  Othe cause of death?  robably 4 □ Unknown  topsy findings available		
Records, P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	enditions con	b. Due to (or as a c. EMP Due to (or as a c.	of pregnance 2 Fetal of time of de	cy death 3 sath 5 string in the un	Ectopic pregnanc Other (specify)  nderlying cause giv  26. Pte	y  ven in Part I.  ace of Death (Colorer: 4  Nursing	23e. Did: 1 24a. Was auto perf 1	Yes 2 an psy ormed? 2 No.	23d. Date of del Month  use contribute to  No 3 Pr  24b. Were au prior to death?  1 Yes	DAYS  IJAAS  Ivery Day Year  In the cause of death?  Irobably 4 Unknown  Itopsy findings available completion of cause of s 2 No		
Records, P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1   Yes 2   No 9   Unknown  Part II. Other significant or DIABETTES  CHRONIC KI  CHRONIC KI  CHRONIC KI  25. Was case referred to me examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5	enditions con  ONEY  Pending	b. Due to (or as a c	or conseque  My S a conseque  of pregnance  time of de  ut not result  when the consequence  consequence  time of de  consequence  cons	cy death 3 anth 5 litting in the un	Ectopic pregnanc Other (specify)  nderlying cause glv  26. Plat 3 □ DOA Other	y  ven in Part I.  ace of Death (C)  er: 4 \( \text{Nursing vat} \)  y  y	23e. Did 1 1 24a. Was auto perf 1 Yes neck only one) 1 Home 5 Resi 28d. Describe	Yes 2 an psy ormed? 2 Note the control of the contr	23d. Date of del Month  use contribute to  No 3 Pi  24b. Were aurent of death? 1 Yes  6 Nother (Specific Specific Specif	DAYS  IJAAS  Ivery Day Year  In the cause of death?  Irobably 4 Unknown  Itopsy findings available completion of cause of s 2 No		
Records, P.O.	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	conditions con	b. Due to (or as a c	of pregnance 2 Fetal of time of de truth not result to the control of the control	cy death 3 sath 5 sath	26. Plate 1 DOA Other Sec. Injury work 1 wet, factory, office	y  ven in Part I.  ace of Death (Corr. 4  Nursing at ?  yes 2 No	23e. Did 1  1 24a. Was auto perf 1 yes neck only one)  1 Home 5 Resi 28d. Describe  FALL  28f. Location (City or To	Yes 2 an psy ormed? 2 X No	23d. Date of del Month  Use contribute to  No 3 Pi  24b. Were aur prior to codeath?  1 Yes  3 Other (Spectory occurred)	iyeny Day Year  the cause of death? robably 4 Unknown topsy findings available completion of cause of 2 No  fify) HOSPICE		
Records, P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	Certificate: To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1	conditions	b. Due to (or as a c	of pregnance 2 Fetal at time of de time of d	cy death 3 cath 5 cath	26. Plate 3 DOA Other sacretary work 1 cert, factory, office	y  y  y  y  y  y  y  y  y  y  y  y  y	23e. Did1  1 24a. Was autoper 1	an psy ormed? 2 X No dence 6 how injury. Street anwn, State;	23d. Date of del Month  use contribute to  No 3 Pi  24b. Were autorior to death?  1 Yes  5 Nother (Special y occurred)  ANE CLUM	DAYS  YEARS  IVERALS  IVERALS  Interry Day Year  In the cause of death?  In th		
Records, P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	Medical Certificate: To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1   yes 2   No 9   Unknown  Part II. Other significant or DIABLETES  CHRONIC KI  CHRONIC KI  CHRONIC KI  CHRONIC KI  25. Was case referred to me examiner? 1   yes 2   No  27. Manner of Death 1   Natural 5   2   Accident 3   Suicide 6   4   Homicide  29a. Certifier 1   Cer (Check 2   Meconly one) 3   Cer	econditions con  ONEY  Pending Investigation Could not be determined  rtifying Physical Examin rtifying Nurse	b. Due to (or as a c	of pregnand 2   Fetal of time of de time of	cy death 3 ath 5 a	26. Plate 3 DOA Other (action) 28c. Injury work 1 200 other (action) 28c. Injury work 1 cet, factory, office	y  y  y  y  y  y  y  y  y  y  y  y  y	23e. Did 1  1 24a. Was autoper 1   Ves neck only one) 28d. Describe  FALL  28f. Location (City or To City or To Cat and due to the cad at the time, date	an psy 2 an an and place an and place are cause(st	23d. Date of del Month  use contribute to  No 3 Pi  24b. Were autrificator to death? 1 Yes  5 Other (Spec. y occurred)  ANE CLUM and manner as state, and due to the cost and manner as	iyends  year  Itivery Day Year  It the cause of death?  robably 4 Unknown  topsy findings available completion of cause of  2 No  Itivity HOSPICE  ral Route Number,  MA.M.D.  ated. cause(s) and manner stated. stated.		
Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1   Yes 2   No 9   Unknown  Part II. Other significant or DIABETTES  CHRONIC KI  CHRONIC KI  CHRONIC KI  25. Was case referred to me examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   2   Natural 3   Suicide 6   4   Homicide  29a. Certifier 1   Certifier (Check 2   Mere	econditions con  ONEY  Pending Investigation Could not be determined  rtifying Physical Examin rtifying Nurse	b. Due to (or as a c	of pregnance 2 Fetal of time of de time of d	cy death 3 ath 5 a	26. Plate t 3 DOA 28c. Injury work 1 DOA 28c.	y  y  y  y  y  y  y  y  y  y  y  y  y	23e. Did 1  1 24a. Was autoper 1   Ves neck only one) 28d. Describe  FALL  28f. Location (City or To City or To Cat and due to the cad at the time, date	an psy 2 an normed? 2 an normed? 2 an normed? 2 an and place are cause(s 29d. Data	23d. Date of del Month  use contribute to  No 3 Pi  24b. Were autrifor to death? 1 Yes  5 Other (Spectory occurred)  ANIC CLUM and manner as state, and due to the cost and manner as state signed (Month)	iyends  year  Itivery Day Year  It the cause of death?  robably 4 Unknown  topsy findings available completion of cause of  2 No  Itivity HOSPICE  ral Route Number,  MA.M.D.  ated. cause(s) and manner stated. stated.		
Records, P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and	Medical Certificate: To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1	enditions conditions conditions conditions conditions conditions conditions conditions conditions conditions are conditional enditions.  Pending Investigation Could not be determined entitying Physical Could not be determined entitying Nurse conditions.	b. Due to (or as a d. Due to (or	or pregnance 2 Fetal a conseque at time of de a conseque at time of de a	cy death 3 cath 5 cath	26. Plat 3 DOA Other (specify)  28c. Injury work 1 Clear (specify)  28c. Injury work 1 Clear (specify)  29c. License  29c. License	ern in Part I.  ace of Death (Control of Part I)  ace of Death (Control of	23e. Did 1  1 24a. Was auto perf 1 yes neck only one)  1 Home 5 Resi 28d. Describe  FALL 28f. Location (City or To 1336 Cit)  1, and due to the cad at the time, date place, and due to the second place.	Acceptance of the service of the ser	23d. Date of del Month  Use contribute to  No 3 Pr  24b. Were aur prior to codeath?  1 Yes  No Other (Spectory occurred)  ANE Countribute to the color of and due to the color of and due to the color of and manner as state signed (Month)	iyery Day Year  the cause of death? robably 4 Unknown topsy findings available completion of cause of s 2 No  ify) HOSPICE  ral Route Number, MAN.MO ated. cause(s) and manner stated. stated. n, Day, Year)  R 6, 2011		
Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 yes 2 No 9 Unknown  Part II. Other significant of DIABETT-S  CHRONIL KI CHRONIC 25. Was case referred to me examiner?  1 Natural 5 S 2 Naccident 3 Suicide 6 S 3 Suicide 6 S Chronic CRONIC	econditions conditions	b. Due to (or as a c	of pregnand 2 Fetal of time of de	cy death 3 ath 5 a	26. Plat 3 DOA Other (specify)  28c. Injury work 1 Clear (specify)  28c. Injury work 1 Clear (specify)  29c. License  29c. License	ern in Part I.  ace of Death (Control of Part I)  ace of Death (Control of	23e. Did 1  1 24a. Was auto perf 1 yes neck only one)  1 Home 5 Resi 28d. Describe  FALL 28f. Location (City or To 1336 Cit)  1, and due to the cad at the time, date place, and due to the second place.	Acceptance of the service of the ser	23d. Date of del Month  Use contribute to  No 3 Pr  24b. Were aur prior to codeath?  1 Yes  No Other (Spectory occurred)  ANE Countribute to the color of and due to the color of and due to the color of and manner as state signed (Month)	iyery Day Year  the cause of death? robably 4 Unknown topsy findings available completion of cause of s 2 No  ify) HOSPICE  ral Route Number, MAN.MO ated. cause(s) and manner stated. stated. n, Day, Year)  R 6, 2011		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28838 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Day Ε. Herman Elizabeth Sept 2011 3:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper House Forest Hill Harford Co. Social Security Number 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🗓 F Months Days Hours Director 218-01-9733 Sept. Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Harford Abingdon 1 Yes 2X No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 21009 111 Grand Oaks Circle United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 XNo 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. "natural", Specify. Completed 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years and Mental Hygie is marked other Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Ogier R. Laura Biddison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mrs. Paulette Shaduk (Daughter) 111 Grand Oak Circle Abingdon, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important; If ite Date Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gdns of Faith Cem. 9/9/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7002 Weep Arro Dundalk, Maryland 21222 any. art 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) should be detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law page 2 autopsy perform 2 🗌 No 1 Tyes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specifical Specifical S 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 XNatural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 24 hours after dear Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Numb Fractionan To the cause of t (Check within 2 29h. Signature and/title of c 29c. License number 29d. Date/signe/d (Month, Day, Year) 30. Name an cause of death (Item 23a) (Type, Print State Registrar

# 11-06014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

oseph Frank Ha	1.	For State (	of Maryland / Depa Ce	artment of rtificate of		iu Mentai r	F	Reg. No.	201	1 28839
Physicia	n/ 1	. Decedent's Name (First, Middle,Last					2. Date of De Month August 1	Day	Year	3. Time of Death  1230 hrs
Medical Examin		Joseph Frank F			4b. City. Town. o	or Location of Dea	August	0, 2011 4c. 0	ounty of Dea	
	ĺ	5201 Springwood Drive	street and number,		Temple Hi			Pri	nce Georg	je's
Funeral		5. Social Security Number unk 6. Se.	7. Age (In yrs.	last birthday)	If Under 1 Ye		_		Fore	irthplace (State or unk
Director		1X	м 2 <u>Г</u> F 78	Yrs	Months Da	ys Hours M	June	17, 19	933 c	ountry)
à	_	Usual Residence of Decedent  10a. State 10b. County	Inc. City	Town or Locat	ion					10d. Inside City Limits
ow any			1 '	emple H						1 Yes 2 XNo
nylanc ka-f sh	Director	10e. Street and Number			10f. Zip Code	-		•	n of What Co	untry?
tth the Maryland 23a or 28a-f show notified at ouce.	Öİ	5201 Springwood	od Dr.		2074	8		US.	A	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner, must be notified at once	a) I	11. Marital Status unk  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? <b>unk</b>	J.S. 13. Wa	as Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or North Rican, etc.)	No- 1	<ol><li>Race - Ame White, etc.</li></ol>	erican Indian, Black,
er deat	Fu		1 Yes 2 No If Yes, Give Year		Yes 2X	lo specify:		s	pecify: 1	olack
ırs afte tural"	<u>a</u>	3 Widowed 4 Divorced  15. Decedent's Education (Specify on	or Dates:	16a. Deceder	nt's Usual Occup	ation (Give kind	of work done un			s/Industry unk
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during n	nost of working li	fe. DO NOT use r	etired)			
within jeer tha	dmc	unk	unk			18 Mother's Na	me (First, Middle	Maiden S	urname) 11r	1k
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be Co	17. Father's Name (First, Middle, Last)	unk			10.100011613140	me (Firet, Middle	, maidon o		TR.
212 212 ould be Ments mark		19a. Informant's Name/Relationship (T	ype, Print )	111		eet and Number				T .
MD nd 2 shc alth and m 27 is		O.C.M.E.	Lan			imore S	t; Balti			223 or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examine		20a. Method of Disposition  1 Burial 2 Cremation 3		crematory or o	sition (Name of o ther place)	zemetery,	Date	200. 20	ocalion only	or roun, case
Baltimore, permit. Pages la Departmen of He Important: If ite		4 Donation 5 X Other Specify. 21. Si mature of Funeral Service Light	in state	122	Name and Addre	ess of Facility St	A	t om v	Poord	
Bal permi Depar Impo injur		21. Signaluled Funeral Service Ch	de Directo			Baltimore				21201
Physician	1	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the deat	h. Do not enter	the mode of dyir	ng, such as cardia	c or respiratory	arrest, shoo	k, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a.	Hypertensive Atherose		diovascular [	Disease				Death
		5	Due to (or as a consequence	of):						
	ě	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):						-254
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
50, te be executed nysician and	Ě	d.						-		
50, te be exe nysician i	ledical	UNPENDED	AMENDED					024	Data at dali	1001
Box 68760, a death certificate be the attending physic ed for use as the bur	M/u	IF FEMALE; 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		etal death	3 Ectopic pre	egnancy		. Date of deliv Month	Day Year
ox 6 ath cert	Physician/N	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of	5 (	Other (Specify)					
b. Bc the der	Phy	Part II. Other significant conditions	9 Ulikilowii	t resulting in the	underlying caus	se given in Part I.	23e. Di	d tobacco u	use contribute	to the cause of death?
r, P.O. Box 6876 rers that the death certificat signed by the attending phe detached for use as the	ð	Diabetes Mellitus; Prosta					1	Yes 2	No 3 F	Probably 4 V Unknown
cords, law requir has been s 2 should b	Completed						24a. W	as an utopsy		autopsy findings available to completion of cause of
eco he law ate has	dwo							erformed? es 2 No	death	
Vital Rec ysician: The l his certificate	Φ	25. Was case referred to medical examiner?		-		ace of Death (Ch				
F Vit Physic r this c	To B	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatie		Other Nu	ursing Home 5		nce 6 🗸 0	ther: Scene
Division of Vital Records, rate or a Attending Physician: The law requir and red edge and red edge and red edge and brector. After this certificate has been seled in by the funeral director, page 2 should I led in by the funeral director, page 2 should I	ion:	1 Natural 5 Pending	(Month, Day, Year)	Zob. Time o		Yes 2 No				
riSior r Attend er death irector: n by the	ertification:	2 Accident Investigat 3 Suicide 6 Could no	28e Place of Injury - A	home, farm, st	reet, factory, office	ce building, etc.			nd Number o	r Rural Route Number, City
Divis pital or At ours after d ceral Direc	Certi	4 Homicide determine					or row	n, State)		
Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying Physic one) 2 Medical Examine	ian: To the best of my knowler:On the basis of examination	edge, death occ	curred at the time	e, date and place, nion_death occur	and due to the or	cause(s) an	d manner as ice, and due t	stated. to the cause(s)
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.			ense number				(Month, Day, Year)
		ano De			0.	.C.M.E.		Aug	just 11, 20	011
		30. Name and address of person who						1		
			ant Medical Examiner		altimore Stre	et, Baltimore	, MD 21223			
S	tate		2. Registrar's Sign		11					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28840 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:06 AM 2011 AMES DIEMBER Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death NI Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs last birthday. If Under 24 Hrs. **Funeral** 1 M 2 D F Min. Director 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director BURNIE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 7 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PAINT TOWANCE Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 0.83 Baltimore, of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donatiof 5 ☐ Other (Specify) 21. Signature of uneral Service 22. Name and Address of Facility per the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate shock, of Interval Between Onset and Death Immediate Cause (Final Ph sician/ Myocavdial disease or condition Medical resulting in death) Examiner avdiomyopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir ymphoma and -tran Due to or as a consequence of resulting in death) Last burial Physician/Medical that the death certificate be Box 68760 phys the k attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Dav signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 PNo 1 Yes Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔊 No 1 Yes |은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 \sum Yes 2 \sum No 1 Natural injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Septembu 9. DO05 2490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Khande Iwaland Hanover St 3001, South

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

FIN

21221

32: Registrar's Signature

Physician/ Medical Examiner Patient known as Levey Harris
Baltimore, Maryland 21215-0036 Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Please	State of Maryla				=	_	libie.	
1 _ State	State of Maryla		ficate of De			201	11 2	8841
Registrar  1. Decedent's Name (First, Middle, La.	est)	Certi	ilcale of De		2. Date of De	Reg. No. U		Time of Death
Leroy Harris	,				Month	Day	Year	2:58AM
4a. Facility Name (if not institution, give	e street and number)	4	b. City, Town, or L	ocation of Death	13CFTC 1122	4c. County		0 0 0 7 1
Sinai Hospitai	e of Baltin	nore	Baltimo	re lite	1			
5. Social Security Number 6. S	IX M 2 □ E			f Under 24 Hrs. Hours Min.	8. Date of Birl		9. Birthplace Country) <b>U</b>	(State or Foreign <b>nK</b>
216-76-7486 Usual Residence of Decedent	67	Yrs.			Dec 25	, 1943		
10a. State 10b. County	10c. (	City, Town or Locat	ion				10d. lr	side City Limits
MD	I	Baltimore	!				1	Yes 2 No
10e. Street and Number			10f. Zip Code	•		10g. Citizen of V	What Country?	
1827 E. 25th St			21215			USA		
11. Marital Status unk 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in L Armed Forces? UNK	J.S. 13. Was	s Decedent of Hisp es, specify Cuban,				e - American Inck, White, etc.	dian,
3 Widowed 4 Divorced	1  Yes 2  No If Yes, Give Year or Dates.	1 🗆	Yes 2 🕅 No	Specify:		Specify:	black	
15. Decedent's E	ducation	16a. Deceden	t's Usual Occupati	on unk		16b. Kind of Bu	usiness Industry	unk
(Specify only highest gr Elementary/Seconday (0-12)	College (1-4 or 5+)		d of work done dur VOT use retired)	ing most of work	mg			
unk	unk						unk	
17. Father's Name (First, Middle, Last)	unk		1	8. Mother's Nam	e (First, Middle,	Maiden Surname	e) unk	
19a. Informant's Name/Relationship (7	Type. Print)	10h Mailin-	Address (Street and	A Number of De	al Dougla Mirant -	r City or Town	Itata Zin C	- 2
Ayodapo Oyelana -			Metro P1					
20a. Method of Disposition	20b.	. Place of Dispositi	on (Name of		Date	20c. Location -		itate
1 Burial 2 Cremation 3 4 Donation 5 Nother (Special	Removal from State	cemetery, cremate	ory or other place)	1 1 1				
21. Signature of Feneral Service Licens Rona I 0	ade, Dicecto		ame and Address					01
23a. Part 1. Inter the disease, r com shock, eart failure. List only o	plications that caused the de	ath. Do not enter the	ne mode of dying,	such as cardiac o	or respiratory arr	rest,	App	roximate
Immediate Cause (Final disease or condition	A CLL to	2201	10.0.	. 0				val Between et and Death
resulting in death)	a. Due to (or as a conse	quence of):	ballo				. 60	iay)
Sequentially list conditions,	b. Preum	onia					30	lays
if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):		12-			10	dain
Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):	euno	nus			0	ray,
	d. Acute	upper	GIA	lood			80	lain
	d	P	-					- ()
ZOD. WILD GOOGGOTE Program	23c. If yes, outcome of pregr		-ta-i- nuovao			23d. Dat	te of delivery	
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		ctopic pregnancy ther (specify)			Moi	nth Day	Year
9 Unknown		10° 4° 10° 1			1			
Part II. Other significant conditions of		esuiting in the unde	erlying cause given	in Part I.		bacco use contr		
Dementia trictal hern	,					Yes 2 □ No		
rucial hern	ia				24a. Was a autop	sy p	Were autopsy fir prior to complet death?	
25. Was case referred to medical			00 Pi	- 6 D 41- (O ! 1	1 🗆 Yes		Yes 2	<del>No</del>
examiner?	Hospital:	TER/Outpatient :	Other:	of Death (Check		S - 011	(016)	
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at			ience 6  Othe		
1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		injury	work? M 1 ☐ Ye	s 2 🗆 No				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street,	factory, office		28f. Location (S City or Tow	treet and Numbe	er or Rural Route	Number,
00- 0-45 45								
(Check 2 L Medical Exami	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of n	on and/or investigat	tion, in my opinion,	death occurred at	the time, date a	nd place, and due	to the cause(s)	and manner stated.
29b. Signature and title of certifier			29c. License nu			29d. Date signed	(Month, Day, Y	
· ·			RES-1	000	-	septon	ber,1	,2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PRIYANKA IMERIMBES  Sinai Hospital of Balto. Balto, MD								
31. Date file <b>SEP</b> , <b>1</b> <sup>ay</sup> <b>2°2011</b>	32. Registrar's Synt	garle						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical **ю** 1 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death WALd D W614 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212-35-9960 1 ☐ M 2 🗷 F 93 Director Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD EllICOTT Houseva 1 🗌 Yes 2 🔼 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral YAW 4747 KESIDENT eyden remanent ろしのイク 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: ASIAN Completed 3 Wildowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. n and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) DWH HOME HOMEMakes other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number\_or Rural Route Number, City or Town, State, Zip Code) TONE Road heone Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State -9-2011 4 Donation 5 Other (Specify) MarriotTSVille, FUNERAL uneral Service Lic 21. Signatere of 22. Name and Address of Facility WITZKE MD Part 1. Enter the disease o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If ist of ty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ner uence of) Examir and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 ☐ Yes 2 ☐ No Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury hours after death. neral Director: Al Accident the f Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 🗆 (Check within 2. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c

State

31. Date filed (Month

2

755

# VOID

CERTIFICATE #

2011 28843

SEE

CERTIFICATE #

2011 30437

State Registrar

**OCME 2006** 

900 W. Baltimore Street, Baltimore, MD 21223

Melissa Brassell, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0935 M Judy Nell Jackson 201 Medical Sepi 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore 5. Social Security Number 6. Sex if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Min. Days Months Hours 1692377947 S. Carolina 215-46-7950 Director 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director TX Yes 2 No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral U.S.A. 1400 East Madison St. Apt813 21213 death v 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: Black Completed 3 🗌 Widowed 4 🙀 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. ementary/Seconday (0-12) College (1-4 or 5+) the Oles Envelope Co. 12th Grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Josephine Good Tom Bagley traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13240 White Moon Ct., Charlotte, NC 28213 Deidre M. Thomas (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation on-site Crematory 09 07/1) 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition MIN / Medical resulting in death) Examiner 3 MOUTS SISTANT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lut as a consequence of death certificate be executed UIT ANY and Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Dav Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed | 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ō 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending Division ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier e and address of person who completed cause of death (Item 23a) (Type, Print) 105 É Inon 31. Date filed (Month, Day, Year, 32. Registrar' State SEP 0 9 2011 Registrar / DHMH 17 Rev 7/2009

11-06498 Dewayne Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 1 28846
State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	e or iviaryland	-	tificate of L		TIG WOILE	,9		g. No.		
Physiciar Medical Examin	-	Decedent's Name (First, Middle, L	•						Date of Death Month	Day Yea	ır	3. Time of Death 2125 hrs
Heulcai Examili		Dewayne Jo 4a. Facility Name (if not institution, g	ive street and number	)	4b.	City, Town,	or Location of I		August 28,	2011 4c, County of	of Death	21251115
		University Hospital				Baltimore						
Funeral	7		Sex 7. Ag	ge (In yrs. la		If Under 1 Ye		24Hrs. 8 Min.			9. Birt Foreig	hplace (State or n
Director			<b>X</b> M 2□ F		23 Yrs.	WIOTIUIS	ays Hours	IVIII I.	08 28	/2011		untry) MD
Á	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location							10d. Inside City Limits
nd show a	<u> </u>	MD		B	AUTIMO	RE						1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number			1	Of, Zip Code			10	g. Citizen of Wh		itry?
72 hours after death with the Maryland n "natural", or items 23a or 28s-f sho	ٲٙ		STREET			21	218			US.	A	
ath wit	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Deceden Armed Forces	?			lispanic Origin an, Mexican, P			14. Race White		can Indian, Black,
fter de		3 Widowed 4 Divorce	1 Yes 2	X No	1 Ye	es 2 🔀 N	lo specify:			Specify:	BU	ACK
ours a	<u>6</u>	15. Decedent's Education (Specify	only highest grade cor	npleted)	16a. Decedent's	Usual Occup				16b, Kind of Bu		
15-0036 Tiled within 72 hour Hygiene. d other than "natu the Medical Exar	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	HVAC			,	' I			merican
5-003(led within Hygiene.	틹	17. Father's Name (First, Middle, La	st)		PIVAL	MPPK			rst. Middle. M	TRAIN aiden Surname)	ING	ACADEMY
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than c event, the Medica	8	GREGORY WA	· ·						JON			
Baltimore, MD 2121, permit. Pages 1 and 2 should be fil Department of Health and Mental Emportant: If iten 27 is marked injury or other transfe event,	2	19a. Informant's Name/Relationship	(Type, Print.)	1-0			eet and Numbe	r or Rura	il Route Numb	per, City or Town		
, MD and 2 sho ealth and cm 27 is	-	MICHELE JONE 20a. Method of Disposition UNK			2635	Book n (Name of c	emetery	GET D	ate UNIF	7/Moral	City or	0 · 212/8 Town, State UNK
Baltimore, Dermit. Pages 1 at Department of Het Important: If ite		1 Burial 2 Cremation 3			rematory or other	place) UA	JK"	5.		Daltimor	ª M	D OZZ
uit. Pa artmer ortani		4 Donation 5 Other Special  21. Sign are of Fungal Service Lice			22. Nam	e and Addre	ss of Facility	1411	GHA) 6	REENE	GII	VERAL Servi
Balti permit. Departn Import	-	23a. Part I. Enter the disease, or con	10/55	3	490	5 Yok	ex ROA	$\mathcal{D}$ .	BAUTI	MORE,	MO	.21212
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on	oplications that caused each line.	the death.	Do not enter the r	node of dying	g, such as card	liac or res	spiratory arres	st, shock, or hea	art	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons			Multip	le Gun	shot	Wound	s		Death
			Due to (or as a coris	equence or								
		if any, leading to immediate	Due to (or as a cons	equence of)	):							
led nisit	Z	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of)	): :							
			±		010	0 16 1	1					
60, ate be execu hysician and the burial - tra	<u> </u>	UNPENDED F FEMALE:	AMENDED 23a			<del></del>	1 SM			Too Lo L		
5876 rtificat ing ph as the		3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	ne ot pregn	ancy 2  Fetal o	death 3	Ectopic pr	egnancy		23d. Date of Month		ay Year
b. Box 687 the death certification by the attending cheed for use as the other forms and other forms as the other forms are the other forms as the other forms are the other forms as the other forms as the other f		1 Yes 2 No 9 Unknow	/n 4 Pregnant at	time of dea	th 5 Other	(Specify)						
C. B. C. B. C. B. C. B. C. C. B. C.		Part II. Other significant conditions		but not res	sulting in the unde	erlying cause	given in Part I		23e. Did tob	acco use contril	bute to t	he cause of death?
ords, P.O. w requires that the same as been signed by should be detacted.								_	1 Yes	2 ✔ No 3	Proba	ably 4 Unknown
Records, The law requires, ficate has been sig									24a. Was ar autops			opsy findings available ompletion of cause of
RecC The lay	<u></u>					-			perform 1 Yes 2	<u>ned</u> ? d	eath?	. 2 No
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical examiner?	Hospital:				ce of Death (Ch		athurtura.			
Physical dir	2	1 Yes 2 No	28a. Date of Inju		ER/Outpatient 3 28b. Time of Injur		Other <sub>4</sub> N	ursing Ho		esidence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law require star dealu.  1 Director: After this certificate has been silled in by the funeral director, page 2 should be prification: To Be Commission.	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	1 Natural 5 Pending	Aug 28, 2011	ear)	2045 hrs		Yes 2 V No	[Cul	bject shot	on analy occurre		
ViSic or Atto firer der Directo in by t	3	2 Accident Investiga 3 Suicide 6 Could no	28e Place of in	jury - At hor	me, farm, street, fa	actory, office	building, etc.	28f.			r or Rur	al Route Number, City
Division o spital or Attending nours after death. neral Director: After filled in by the fune		4 Momicide determin		al Street	t			280	or Town, Sta 0 Blk. Roun	id Road, Baltir	nore, N	MD
Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the defined for use as the defined for the Director and Committed by the Director and Committed by the Committed by t			cian: To the best of mer:On the basis of example.	-								
To To Toom Com		9b. Signature and title of certifie	and manner stated.	* * /	7		se number			29d. Date signe		
		H. 18 (1) Mo-	1/06/2	1236	e contract of the contract of	0.0	.M.E.			August 29,	2011	
	3	0. Name and address of person who		,	•	1	<del></del>					
			Assistant Medical			Baltimore :	Street, Balt	imore,	MD 21223	3		
Stat Registra	e s Ir	SEP 0 9 2011	32. Registra	Signature	arke							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Se Ptember Day Robert Jackson 7:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours Director 213-62-1090 1 XM 2 🗆 F 57 02 11 54 NC Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code č 10g. Citizen of What Country? must be Funeral 23a 1635 Ingram Road 21239 U.S.A. ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Completed by altimore, Maryland 21215-0036 Yes 2X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade lyr Construction Worker Various Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calphonso Thompson Ora L. Parker other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ora Robinson-Mother 1635 Ingram Road, Baltimore, Md 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) injury or Department Important: I any injury or once. On-Site 997/2011 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, al Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung (an ler disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): physician at s the burial-1 Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by the Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? or Attending Physician: The 1 🗌 Yes 2  $\square$  No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) has pice 2 - No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) as Ray apalone M.D D0057465

Registrar
DHMH 17 Rev 06-2011

State

2835 Smith AV

5 203

Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rajapall SI, MID

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 28848 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Helen P. Kalandros 2011 5:40 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Mays Chapel Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug • 11 9. Birthplace (State or Foreign Country) Ohio **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🗓 F Days Hours **Director** 220-30-4679 Yrs 94 917 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😿 No MD Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 12251 Roundwood Road #107 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 XWidowed 4 Divorced At. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Manuel N. Pavles Clara Thanos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Theodore Kalandros</u> 12251 Roundwood Road #107: Timonium. MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specifient on Dentation) 9/14/2011 Greek Orthodox Cem. Woodlawn, MD Signature of Fune et Service/ ide 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see on each line. 23a. Part 1. Enter the disease, or complicat Approximate Interval Between Onset and Death shock, or heart failure. List only one of Immediate Cause (Final St Physician/ -d disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, iner if any, leading to immediate Due to (or as a consequence of) Physician/Medical Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last vision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ☐ Live Birth 2 ☐ Fetal 4000 ☐ Pregnant at time of death Day Year been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 (No death? 1 ☐ Yes 2 ☐ No Funeral Director: After this certificate Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of **Certificate:** 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title RO7954

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of per

31. Date filed (Month) Day Year)

670

Tow son

ompleted cause of death (Item 23a) (Type, Print)

312

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 2 2011 11.58 PM EDWARD STANLEY KOSLOWSKI Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death SLEN BURNIE BATIMORE WHETHINGTON MEDICAL CENTR If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Hours 05 01 1916 215 05 0911 95 Country) **Director** MD Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 209 Glen Rd 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 X Yes 2 No 1945

If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 1946 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life, DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11and Die Maker n and Mental Hygier 7 is marked other t Tool Westinghouse Corp. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Stanley Koslowski Balbina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trat Angelina Koslowski 209 Glen Rd - Wife Pasadena, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/7/11 Glen Haven Mem Pk Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sonoral 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** MONIF Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examir and I-transit ME or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? signed by the atte Year Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No ပ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 24 hours after death. Funeral Director: A 2 No 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide completed filled in by the Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis or examination.
3 Certifying Nurse Presidents To the best of my least Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of certifier tress of person who completed cause of death (Item 23a) (Type Print) 301 Hospital 31. Date filed (Month, D.y, 32. R State Registrar OHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan				Mental Hy	giene		
			State Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of De	eath		Reg. No.20	28850 3. Time of Death	
	Physicia Medic	cal	Nathan		Kei			Septem	eptember 4 2011 17		
A.	Examir	ner		ns Hospital		Baltimi	ore Ut	y	4c. County of Dea	th	
	Funeral Director			M 2 □ F 7. Adje ( <i>in yrs. la</i>	ast birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Dec 1	v. Year) Co	thplace (State or Foreign buntry)	
	and show lat	5	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits	
	Maryla 28a-f	Director	MD	E	Baltin	nore				1 🔀 Yes 2 □ No	
	with the s 23a or ust be r	Funeral D	10e. Street and Number 201 N. Washingto	on St.		10f. Zip Code	.213		10g. Citizen of What C USA	ountry?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	δ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 ☐ No X		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify:	te, etc.	
1215-(	hin 72 hou ne. <b>than "nat</b> u <b>e Medica</b>	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		16a. Deced (Give I life. De	16b. Kind of Business					
d 2	ed wit Hygiel other ent, th	Be C	12th 17. Father's Name (First, Middle, Last)		Stoc		8 Mother's Nan		Grocery S Maiden Surname)	Store	
ylan	uld be fil   Mental   marked   natic ev	ျ	Nathan Kelly,					l Till	,		
Mai	d 2 shoralth and 127 is n		19a. Informant's Name/Relationship (Type Elsie M. Kelly		T	•			r, City or Town, State, Z to, Md。 2]		
Baltimore, Maryland 21215-0036	Page 1 an nent of He int: If iterr iry or othe		20a. Method of Disposition  1 Surial 2 Cremation 3 Re 4 Donation 5 Other Specify)	20b. P	lace of Dispo	sition (Name of natory or other place) Cem.		Date	20c. Location - City o	r Town, State	
Balti	permit. Departr Importa any inju	(	21. Signature of Funeral Service Licens	1	22 C	Name and Address	of Facility Scrug	gs Fun	eral Home	21213	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	n. Do not ente	r the mode of dying,	reston such as cardiac	or respiratory arr	alto, Ma.	Approximate Interval Between	
- F	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	rneum on 1						Onset and Death	
	Examiner	<u>.                                    </u>	Sequentially list conditions, b.	Due to (or as a consequ	erice oi):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Due to (or as a consequ	equence of):						
	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	ence of):						
68760	tificate ng phys as the	Medi	d.								
. Box 6	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.   The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		c. If yes, outcome of pregnar 1  Live Birth 2 Feta 4 Pregnant at time of d g Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
Js, P.C	luires that t	by	Part II. Other significant conditions control	ibuting to death but not resu	ulting in the u	nderlying cause given	in Part I.	23e. Did to	obacco use contribute t Yes 2 XNo 3 🗆 F	o the cause of death?  Probably 4 Unknown	
Division of Vital Records, P.O.	<b>Physician:</b> The law rec this certificate has ber al director, page 2 sho	Completed						24a. Was a autop perfo	osy prior to	utopsy findings available completion of cause of	
tal	cian; ærtifici ector,	Be	25. Was case referred to medical examiner?	spital: 🔨			e of Death (Chec		7		
of Vi	g Physi er this c eral dir	e: To	27. Manner of Death	1 N Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury at			lence 6 Other (Specow injury occurred	cify)	
sion	ttending death. stor: Afte / the fun	Certificate:	1 A Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury		s 2 $\square$ No	006 1 1 10		10 1 11 11	
Divis	Io the Hospital or Attending Phymithin 24 hours after death.  To the Funeral Director: After th completed filled in by the funeral		4  Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, rarm, stre	ет, тастогу, опісе		28f. Location (S City or Tow	treet and Number or Ru n, State)	iral Houte Number,	
:	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Examiner	an: To the best of my knowle : On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinion,	death occurred a	it the time, date a	nd place, and due to the	cause(s) and manner stated.	
	No the with To the com		29b. Signature and title of certifier			29c. License no			29d. Date signed (Mont	h, Day, Year)	
2	70		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, P			t Bal	timore 1	10 21287	
Ĭ	Stat Registra		31. Date filed (Month, Day, Year) SEP 12 201	32. Redistrar's Signate	ure	NUTTO	- 1100	J. W(1	14.101 ( ) 11	ו טוניוט טו	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2885 I 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AΜ September 2011 9:15 eRoy Ralph Leifer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Senior Living Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 389-10-4953 Director 1 X M 2 □ F 94 March 24, 1917 Wisconsin show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code ms 23a or must be r ō 10g. Citizen of What Country? Funeral 20715 3006 Traymore Lane IISA er than "natural", or items the Medical Examiner mu death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give 1941 Year or Dates 1942 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) United States Elementary/Secondary (0-12) Research Professor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ဂ Paul Ernst Gottlieb Leifer Lydia Back Havs traumatic ge 1 and 2 should be nt of Health and Men : If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Leifer/ Son 3006 Traymore Lane Bowie, MD 20715 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Mary Land 1 X Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 9/9/2011 Crownsville, MD 21. Signature of Funeral Servi 22. Name and Address of Facility Robert E. Evans Funeral Home mi 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or Injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Vear the Division of Vital Records, P.O. ģ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed?

Yes 2 X No death? certificate 1 Yes the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No 4 🗌 Nursing Home 5 🗌 Residence 6 🕻 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at Certificate: eral Director: After filled in by the funer 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47447 September 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Laziriz M.D. 6334 Cedar Lane Columbia, MD 21044

DHMH 17 Rev 06-2011

Registrar

32. Ramar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of N	Maryland					and M	1ental Hyg	giene _	011	0.0	0.50
												Reg. No. Z	UII	28	852
	Physicia	an/	Decedent's Name (First, Midd	,								2. Date of Death Month Day Year			of Death
1	Medic	cal		dehunoluwa	Layeni	-	T T				Septemb	tember 3 2011 2:			P M
	Examin	ner	4a. Facility Name (if not institutio		)		4b. City		Location of			4c. County of Death			1
web			Holy Cross 5. Social Security Number		A a a //a	for institution of a col	If I Ind		er Sp				Montgo		- Francisco
	Funeral Director			1 X M 2 - F	Age (In yrs. last	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day	Year)	Cour		or Foreign
		1	n./a. Usual Residence of Decedent						2	30	Sept. 3	, 201	l Mary	Land	
	and shov	į	10a. State 10b. Count	/	10c. City, T	own or Loc	cation							10d. Inside	City Limits
	Maryl 18a-f tiffier	Je C	MD Princ	e George's	IInne	r_Mai	rlho	ro						1 🗶 Y	′es 2 ☐ No
	the l		10e. Street and Number					ip Code				10g. Citizen	of What Cou	ntry?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	15622 Ccpp	er Beech Dr	ive			20774					JSA		
	death item ier n	Ξ	11. Marital Status	12. Was Deceden Armed Forces		13. V	Vas Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri		
36	after ", or camir	þ	1 Never Married 2 Ma	rried 1 Yes 2				-	Specify:				Black, White, c <i>ify:</i> Afr		
21215-0036	ours a	Completed	3 Widowed 4 Divorce	Year or Dates.									Ame	rican	
15	72 h n "na Nedio	햩	(Specify only high	est grade completed)		16a. Deced (Give F	kind of w	ual Occupa ork done d se retired)	ation <i>uri</i> ng mosi	t of worki	ng	16b. Kind o	f Business In	ndustry	
112	/ithin iene. r tha the A	S	Elementary/Seconday (0-12) Infant	College (1-4 o	r 5+)	iiie. Do	Infa						T., C		
	al Hyg d othe	Be	17. Father's Name (First, Middle,	Last)			Lills	1111	18. Mothe	er's Name	e (First, Middle, I	Maiden Surn	Inf.	anr	
lan	ould be filed within 7: nd Mental Hygiene. marked other than matic event, the M6	은	Oladipupo	Layeni					0	yinw	rola Nh	inlam	,		
Maryland	should be file and Mental H 7 is marked o raumatic eve		19a. Informant's Name/Relations		- 1	19b. Mailin	g Addres	ss (Street a		_	I Route Number		-	Code) 2.0	0774
	and 2 s Health a tem 27 i		Oladipupo La	yeni/Father	"	15622	c Cc	pper	Beec	h Dr	ive, U	pper 1	Marlbo	ro. MI	D
Baltimore,			20a. Method of Disposition	. □ □ . I		e of Dispo	sition (Na	me of	- 1		Date		on - City or T		
Ĕ	Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (			te of	-		1	9/9/	2011	Silve	er Spr	ing. N	MD
alt	permit. Page Department Important: any Injury o		21. Signature of Funeral Service	Licensee		22	. Name a	nd Addres	s of Facilit		naldson				
	20 <b>= 2</b> 0	1	Lanuci	31/200K	M0110 ر						, Laure		2070	7	
			23a. Part 7. Enter the disease, c shock, or heart failure. List	r complications that caus only one oause on each li	ed the death. Dine.	o not ente	r the mo	de of dying	, such as	cardiac o	r respiratory arre	est,		Approxim Interval B	Between
	hysician/	8 %	Immediate Cause (Final disease or condition	Pı	ulmonar	у Нур	opla	sia					1	Onset and 2 1/2	d Death hrs
-	Medical Examiner		resulting in death)	Due to (or a	s a consequen	ce of):									
		je je	Sequentially list conditions,	b. —	nhydram								-	<u>7_weel</u>	ĸs
	sit sit	i i	cause. Enter Underlying Cause (Disease or iinjury	Due to lor a	s a consequen	ne ch									
	ecute and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequen	ce of):							-		
0	or Attending Physician: The law requires that the death certificate be executed after death.  Jifector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dicall	,		,	,									
760	cate phys			d											
Box 687	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			1					23d.	Date of deliv	/erv	
30X	eath e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	n 2 🗐 Fetal de tat time of deat		Ectopic Other (s		У			-55	Month	Day	Year
Ö.	t the dea by the a tached	hys	9 🗌 Unknown	9 🗆 Unknowr	n										
P.O.	es that igned k be det		Part II. Other significant conditi	ons contributing to death	but not resulting	ng in the u	nderlying	cause giv	en in Part	l.	23e. Did to	bacco use c	ontribute to t	he cause of	i death?
ds,	requires been sig	pa	Prematurity								1 🗆 Y	′es 2XXXN	o 3 🗆 Pro	bably 4	Unknown
Sor	w rec	ple	Chorioamnio	nitis							24a. Was a		b. Were auto	psy finding	s available
Re	The law ate has page 2	Completed by									perfor	med?	death?		
of Vital Records,	ysician: The is certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Pla	ice of Dea	th <i>(Check</i>					
Ž	Physic this coral dire	은	1 🗆 Yes 2 🔀 No	Hospital: 1X Inpa	atient 2 ER	/Outpatien	t 3 🗆 🗅	Othe	r: 4 □ Nu	ursing Ho	me 5 🗆 Resid	ence 6 🗆 (	Other (Specif	y)	
101	ding P h. After t funera	ate:	27. Manner of Death 1	28a. Date of in (Month, D	ijury 28 Day, Year)	b. Time of injury		28c. Injury work	?		28d. Describe ho	ow injury occ	curred		
io	ttend death tor: / the f	iţi		gation not be			М		Yes 2 🗆						
Division	al or Attendii s after death. I Director: Af d in by the fu	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Follows) 28d. Describe how injury occurred 3d. Describe how injury occu								ıl Route Nui	mber,				
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th		29a, Certifier 1 X Certifying	Physician: To the heet of	of my knowledg	ae, death o	ccured a	t the time	date and	place an	d due to the cau	se(s) and m	anner as state	ed.	- 13
	e Hos 124 h e Fur eleted	Medical	29a. Certifier 1								manner stated.				
	To the within 2 To the comple	2	29b. Signature and title of certifie		y &II		T	c. License		a.a plat			ned (Month,		
	1 12		Mutter B	I care Mi	110.			D0050	522			Sept	ember	3, 20	)11
	18		30. Name and address of person	who completed cause of	death (Item 23	a) (Type, Pi	rint)				I				
			Matthew B. I			ores	t Gl	en Ro	ad,	Silv	er Spri	ng, MD	2091	LO	
	Stat Registra		31. Date filed (Month, Day, Year)  SFP 1 2		trar's Signature	Mas	Med								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar 28853 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katie Lynn Landers September 9 2011 2:20 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2627 A Greene Road Baldwin Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 212-02-0429 Director 29 1 🗆 M 2 🗶 F December 8, 1981 Maryland Usual Residence of Dec 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified Maryland Baltimore Baldwin 1 Yes 2 X No 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? must be 23a 2627 A Greene Road 21013 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner , or it Armed Force Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify. "natural", Specify White Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Driver Currier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Landers Donna Cornecelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Landers/Father 3304 Batavia Avenue Baltimore, Maryland 21214 Department of Health Important: If item 27 any injury or other th once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 9/14/11 Towson Maryland Signature of Euneral Service Licens 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital 'Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Pregnant at time of death 1 Yes 2 L 9 Unknow the 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, eral Director: After this filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Prantitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANCY State

DHMH 17 Rev 06-201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J. Sept. William Landry 2011 5:02 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7331 Waldman Avenue Edgemere Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1**XX**M 2 □ F Months Days Sept. 23, 1930 **Director** 023-22-7632 80 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Edgemere Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21219 7331 Waldman Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: **¾X**Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Mechanic 6 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Rose Bussiere Joseph P. Landry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3206 McShane Way Dundalk, Maryland 21222 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mr. David W. Landry (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland Donation 5 Other (Specify) Hilltop Service Corp. 9/10/2011 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7022 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Licensee 1nc. 21222 Part 1. 5 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) hoon Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed page 2 PNo 1 🗌 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 🗆 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of o

Registrar DHMH 17 Rev 7/2009

State

30. Name and add

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

124ct

ges of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28855 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Month Norma Lorraine Lewis 7:55 PM Medical Eacility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death lin Squa Rosedale re Hospita Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
NOV • 23, 1933 9. Birthplace (State or Foreign Country) Maryland **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🔀 F 218 28 6185 77 Director Usual Residence of Decedent ortant, If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1023 Foxwood Lane 21221 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married δ LEWIS J Normal Baltimore, Maryland 21215-0036 should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis J. Nelson Florence M. Harryman 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Mae McNew (Sister) 52 Poppy Ct. Parachute, Colorado 81635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/15/2011 Baltimore, Maryland 22 Name and Address of Facility
Bruzdzinski Funeral Home P.A. Signature of Funeral Service License 1407 Old Eastern Avenue Essex, Maryland 21221 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Hemorrhage erebrovasewar Physician/ Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 N 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 1 Yes 2 1 No 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 🗆 Yes 2 🗆 No 5 Pending within 24 hours after death To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/1 0

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Da SEP 12 20 completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28856 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 38 2011 2:14 Elmer Liverpool August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hyattsville Prince Georges St. Thomas More Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Hours oct 17, Pay, Year 1928 Washington, DC Director 82 577-36-3155 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Prince Georges Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20782 4922 LaSalle Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) food industry dishwasher unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jane Thompson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 6121 Osborn Rd; Hyattsville, MD 20785 Bruce McInnis - nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Hother (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the dilease, \*F omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital Records, Hospital or Attending To the within 2

Box 68760

P.O.

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 7/2009

Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063681

y Blud HYAHSVIlle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph F. Lord, Jr. 6:15  $P^{M}$ September 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore MD. Presbyterian Home Towson . Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign (Month, Day, Year) 152-30-7244 Director 1 😿 M 2 🗆 F 72 March 1, 1939 New Jersey Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD. Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Georgia Court 21204 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Secondary (0-12) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph F. Lord, Sr. Sara Heller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the Christopher Lord/ Son 8114 Halton Rd. Towson, MD. 21204 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 9-10-11 Towson. MD. Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Juneral 2 rvice complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
One week Immediate Cause (Final Ph sician/ disease or condition resulting in death) nehmonia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) g physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? this certificate has been signed by the atterral director, page 2 should be detached for Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 1 Yes 2 13 No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 X-No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 Natural work? 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier

within 24 hours after death.

To the Funeral Director: After completely filled in by the funer the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) September 9, 2011 29b. Signature and title of certifier D37016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kerlen M. Green, no 6701 N. Charles St., So to 4104 Selthon, no 21204 31. Date filed (Month) Day-Year) State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Antonio Laws	Registrar Reg. No.	8858
Physician Medical Examine	Ambromio Creocoratt Intto 120	of Death 9 hrs
	4a. Facility Name (if not institution, give street and number)  516 North Chester Street 2nd floor  4b. City, Town, or Location of Death  Baltimore  4c. County of Death  N/A	
Funeral Director	5. Social Security Number 216-96-1615 6. Sex 1. Age (In yrs. last birthday) 1. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (\$\frac{1}{2}\text{Implicit} \text{Months} \text{Days} \text{Hours} \text{Min.} \text{1/2/1980} \text{Foreign Country)}	State or MD
ee Maryland or 28a-f show any fied at once.	MD N/A Baltimore	side City Limits
the Maryland 3a or 28a-f sh otified at once	10e. Street and Number  10f. Zip Code 10g. Citizen of What Country? 21215  USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Tes 2 X No specify:	n, Black,
5-0036 ed within 72 hours bygiene. other than "natun the Medical Exam	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Chef  Lenny's Inne	r Mac
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	Antonio G. Laws, Sr. Sandra Fowler	
MD 21  d 2 should 1  sh and Mer  m 27 is man  aumatic ev	Sandra E. Chandler-Mother 5204 Beaufort Ave. Balto., MD 21215	
Baltimore, permit. Pages I an Department of Hes Important: If iten njury or other tr	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  King Memorial Park 9/10/2011 Randallstown	, MD
	21. Signature of meral Service Cansee  22. Name and Address of Facility March F/H 1101 E. No Ave. Baltimore, MD 21202	rth
Physician /Medical Examiner	failure List only one cause on each line.  Immediate Cause (Final disease a Multiple Gunshot Wounds	ximate Interval en Onset and Death
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
executed an and al - transit	d.  UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
cath certificath carting for use as t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 23d. Date of delivery Month Day  Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
es that the destand by the detached	1 Yes 2 No. 3 Probably 4	
Division of Vital Records, talor Attending Physician: The law requirers after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	24a. Was an autopsy find autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes	
Vital ysician ysician director		
ion of Vital treating Physician: death.  tror: After this certify the funeral director, attion: To Be (	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: 1 Yes 2 No Subject shot  28b. Time of Injury 28b. Tim	
C File bound		
Di To the Hospital within 24 hours a To the Funeral I completely filled	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  **The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	5)
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, O.C.M.E.  September 5, 2011	Year)
	30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sentemb 25PM ZVII **EUNICE MARCELLA LISTMAN** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Min Hours 216 34 1523 Director 7.3 Usual Residence of Decedent show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 23a or 28a-f MD Anne Arundel 1 Yes 2 No Pasadena 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 701 C Street 21122 U.S.A. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Brannock's Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Bus Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter F. Jones, Jr. Emma Louise West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Listman - Husband 701 C St. Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/9/11 Glen Haven Mem Pk Glen Burnie, MD 21. Signature of Surieral Sovice Licenses 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Riviera Drive Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Securitary list no dition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy perform death? 2 XNo Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie To the Hosp within 24 ho To the Fune completed fi (Check only one Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated le of certifier 29b. Signature and t 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 State 32

DHMH 17 Rev 7/2009

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER Day 09 2011 BERNICE 03:40 AM LEMBERG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE OF HOWARD COUNTY COLUMBIA HOWARD 9. Birthplace (State or Foreign Country) NY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🗓 F Months Days Hours 12719718 **Director** 051-12-8490 92 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No NJ **MIDDLESEX** OLD BRIDGE 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 19 MERCER ROAD 08857 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 → Widowed 4 □ Divorced Year or Dates WHITE Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLES OKEN **BERTHA PEVSNER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETH L. HIMA/DAUGHTER 9305 MEADOW HILL ROAD, ELLICOTT CITY, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SOLOMON MEM.PARK 09/11/2011 CLIFTON, NJ Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
DAYS Immediate Cause (Final Physician Cerebrovascular accident disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter chaorying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Day Year Pregnant at time of death Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform 2 No Yes 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) Hospice 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier CRNF

State Registrar CEDAR LANE Columbia, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D (AC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death

8:35 а.ш. 2011 SEPTEMBER 5,

DANIEL LARDIERI

			For State Registrar	State of Maryland		tificate of E			Reg. No. 0		28861
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last  Daniel Rocco La					2. Date of Dea Septemb		20 <sup>Y</sup> f¶	3. Time of Death 8:30 A M
AAL	Examir		4a. Facility Name (if not institution, give s			4b. City, Town, or <b>Timoni</b>	Location of Death		4c. Count		ro
العب	Funeral		5. Social Security Number 6. Se.	THO DE	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	n	9. Birthi	place (State or Foreign
	Director ≥		144-14-9311 Usual Residence of Decedent	88 88	Yrs.	World Buys	Trouis Will.	Aug 21,	1923	Men	Jersey
	aryland a-f sho fied at	Director	10a. State 10b. County  MD Baltim		Town or Loc ings M					1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a or 28 be noti		10e. Street and Number			10f. Zip Code			10g, Citizen of USA	What Cou	
	eth with	Funeral	4730 Atrium Ct.	12. Was Decedent Ever in U.S.	13. W	21117	spanic Origin? (Sp			ce - Americ	
Maryland 21215-0036	urs after de tural", or it	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No 4/17  If Yes, Give Year or Dates. 3/21/	/ <del>-</del> P	/as Decedent of His Yes, specify Cubar ☐ Yes 2X No		Rican, etc.)		ck, White,	etc.
215-	n 72 ho e. an "nat Medica	mple	15. Decedent's Edi (Specify only highest grad Elementary/Seconday (0-12)		(Give ki	ent's Usual Occupa ind of work done d NOT use retired)		king	16b. Kind of E	6b. Kind of Business Industry	
d 21	ed withi Hygiene other th	Be Co	8 17. Father's Name (First, Middle, Last)	0	tea	mster	40.14.11.1.11		unio		
ylan	d be filk Mental   arked c	일	Guiseppe Lardie	i			18. Mother's Nam	na Loung		e)	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	18	19a. Informant's Name/Relationship (Type E. Gregory Lard			g Address (Street a 5D Hanove					
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☑ Donation 5 ☐ Other (Specify)			ition (Name of atory or other place	e)	Date	20c. Location	- City or To	own, State
Ball	permit Depart Import any in	à	21. Signature of Funeral Service License Ronald S W	no, pirector	22.	Name and Addres	s of Facility <b>S</b> ta altimore		-		21201
-i.	hysician Medical Examiner		23a. Par 1. Enter the disease, or complete shoot, or heart failure. List only one shoot of the complete shoot	cations that caused the death. It is cause on each line.  ASPIRATION P  Due to (or as a consequent	NEUMOI		g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or linjury	Due to (or as a consequen	ice of):						
0	icate be executed I physician and s the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a consequen	ice of):		-				
ox 68760	or Attending Physician: The law requires that the death certificate be executed after death. Darker death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy	eath 3	Ectopic pregnancy	/			ate of delive	
P.O. Box	the dea by the a ached f	hysic	1  Yes 2 No 9 Unknown	4 Pregnant at time of dea	th 5 □	Other (specify)			IVIC	onth	Day Year
rds, P.(	requires that the de been signed by the s should be detached	by	Part II. Other significant conditions cor	tributing to death but not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did tol	C)		pably 4 Unknown
Reco	<b>Physician:</b> The law re this certificate has b al director, page 2 sh	Completed						24a. Was a autops perfore 1 \(\sime\) Yes	sy med?	Were autop prior to con death? 1  Yes	osy findings available mpletion of cause of 2  No
Vita	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	ospital: 1 ☐ Inpatient 2 ☐ ER	2/Outnatient	Othor	ce of Death (Chec		6 <b>V</b> 04	(Cif	HOSPICE
Division of Vital Records,	ending Ph eath. or: After thi he funeral (	Certificate: 1	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation		b. Time of injury	28c. Injury	at	28d. Describe ho			HUSPICE
DIVIS	ital or Atteno ins after death al Director: / led in by the l		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
	To the Hospital of within 24 hours a To the Funeral D completed filled in	Medical	only one) 2 Medical Examine only one) 3 Certifying Nurse	ian: To the best of my knowledger: On the basis of examination ar Practioner: To the best of my kn	nd/or investic	ation, in my opinior	<ol> <li>death occurred a</li> </ol>	t the time, date an	diplace and du	e to the car	ise(s) and manner stated
	or North		29b. Signature and title of certifier	MAR		29c. License	714070	12 2	9d. Date signe	d (Month, E	Day, Year)
		Ì		npleted cause of death (Item 23		· ·	<del>\ ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (</del>		11 (2)	0-11	
	Stat	e	JACKÍE JONES, CRI	NP 2300 DULANI 32. Registrar's Signifiure	Y VAL	LEY RD.	TIMONIU	M, MD 21	.093		
	Registra	ır	SEP 1 2 2011	Serve B.	your						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28862 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician 20°1′1 1:30 PM August Patricia Ann Maggard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Union Bridge 122 N. Main St. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. May 16, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Maryland May 217-48-5422 51 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Marcial Examinar mass to 28a-f show once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Union Bridge 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 N. Main St. 21791 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify. \$ 3 Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n clothing seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Halbert E. Robertson Edna Gertrude Bankert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Maggard - daughter 122 N. Main St; Union Bridge, Maryland 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Si nature o Fi neral Se vio 22. Name and Address of Facility State Anatomy Board Director 21201 655 W. Baltimore St; Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician; The certificate perform 2 No 1 □ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 □ No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of After t 28d. Describe how injury occurred 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director; Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, 30. Name and address person who completed cause of death (Item 23a) (Type, Print) BOUMEMORIAL LANE OHANNA 11 10 31. Date filed (Month. State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryl Registrar	-	artment of Health a tificate of Death		iene <sub>eg.</sub> 2011	28863	
П	Dharisis	/	Decedent's Name (First, Middle, Last)			<ol><li>Date of Deat</li></ol>	h	3. Time of Death	
	Physicia Medic	cal	Chong Im McKernan				er 6, 2011	9:35 P <sup>M</sup>	
"Herey"	Examin	ier	4a. Facility Name (if not institution, give street and number)  Casey House Montgomery Hospic	:e	4b. City, Town, or Location of Rockville	f Death	4c. County of Death  Montgomery		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In your 216-80-6500 7. Age (In your 216-80-6500 82	rs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day, Dec. 1		rthplace (State or Foreign ountry) uth Korea	
Т	nd now at	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or Loc	ation			10d. Inside City Limits	
	farylar 3a-fsl tified	Director		lver Spr				1 X Yes 2 No	
	the Manager or 28		10e. Street and Number	TVC1 Opt	10f. Zip Code		0g. Citizen of What C		
	th with ns 23; must I	Funeral	440 University Blvd. #417		20901		USA		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates,	lf	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican  ☐ Yes 2 ☑ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify: Ac		
2-0	hours natur	olete	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupation		16b. Kind of Business		
Baltimore, Maryland 21215-0036	3 Widowed 4 Divorced Tres, Give Year or Dates.  16. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  12 Homema ker							,	
d 2	iled will Hygik other	Be	12 17. Father's Name (First, Middle, Last)	nonen		er's Name (First, Middle, N	Own Home		
ylar	ld be f Menta iarked atic ev	욘	Sanggun Oh		Chuny				
Mar	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Numbe Westwind Driv			ip Code)	
<u>e</u>	1 and of Heal item 2		Geemin McKernan/ Daughter  20a. Method of Disposition 20l	b. Place of Dispos	sition (Name of		20c. Location - City o	r Town, State	
imo	. Page ment c tant: If lury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Nat. Cem.	9/16/2011	Arlington,	VA	
Ball	permit Depart Impor any in		21. Signature of Puneral Service Licensee		Name and Address of Facility				
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not enter	r the mode of dying, such as o	cardiac or respiratory arre	st,	Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)					Onset and Death	
	Examiner		Due to (or as a cons	equence of):					
	ii. q	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. — Due to (or as a cons	equence of):					
	xecute and al-trans	Exan	Cause (Disease or linjury that initiated events c	equence of):					
တ္တ	icate be executed physician and s the burial-transit	edical	d						
3876	ertificat ling ph e as th	/Mec	IF FEMALE:						
Box 68760	eath ce attenc I for us	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No 4 Pregnant at time.	Fetal death 3 📙	Ectopic pregnancy Other (specify)		23d. Date of de Month	eliv <b>e</b> ry Day <b>Y</b> ear	
о В	the deby the	hysi	9 Unknown 9 Unknown						
, P.O.	es that signed be de'	þ	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause given in Part I.		acco use contribute to		
ords	requir been s	letec	Right Sided Heart Failure				T	robably 4 Unknown	
Sec.	Physician: The law this certificate has ral director, page 2 and the control of t	Completed	-			24a. Was an autops perform	prior to	completion of cause of	
<u>e</u>	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?		26. Place of Death		LANo 1 □ Ye	s 2 🗆 No	
Ę	Physic this or	은	1	ER/Outpatient		rsing Home 5 Reside		oify) Hospice	
o uc	nding ath. r: After e funel	icate	1  Natural 5  Pending (Month, Day, Year) 2  Accident Investigation		28c. Injury at work? M 1 ☐ Yes 2 ☐ I	28d. Describe how	v injury occurred		
Division of Vital Records,	or Atte fter de lirecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stree	et, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,	
۵	spital cours a leral D	edical C	29a. Certifier 1 Certifying Physician: To the best of my know	owledge death or	coursed at the time date and a				
) ,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medi	(Check 2 Medical Examiner: On the basis of examina only one) 3 Certifying Nurse Practioner: To the best of	tion and/or investi	gation, in my opinion, death occ	curred at the time, date and	Inlace and due to the	cause(s) and manner stated	
	To t		29b. Signature and title of certifier	- 1 0	29c. License number		d. Date signed (Monte		
	, (		30. Name and address of person who completed cause of death (It	CRNP	R143201		9/7/2011		
	1		Debrah Miller, CRNP 6001 Mun	, , , , ,	<u>Mill Road Derw</u>	ood, MD 208	55		
	Stat Registra	e r	31. Date filed (Month, Day, Year) 32 Registrar's Sig	natur					
				, (7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Evelyn Marie Moscati 5:20 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Dulaney **Baltimore** Lowson Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth October 1 □ M 2 🗶 F 96 Months Days Hours Min 215-03-5916 Director Yrs Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3305 Gibbons Avenue 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical and solve the straumatic events. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrator Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Pasquale Moscati Rosetta Romano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Seidl/great niece 3305 Gibbons Avenue Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Dulaney Valley Mem. Garden's 9/12/11 Timonium Maryland 21. Signature of Funeral Service Licens reconant J. Ruck Frailty S305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval Between shock, or heart failure. List only one cause on each/line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the sale g 🗌 Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of has page 2 autopsy performed' death? After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 29b. Signatı Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 28865 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 22:43 PM ALBERT L. MARSH 201 Septembe 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ▼ M 2 □ F 209-05-4971 Feb. 8,1917 Pennsvlvania Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Edgemere 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3100 Greenhill Road 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates: WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tyes 2x7XNo Specify 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Marsh Freda Eckstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda L. Brown (Daughter) 3100 Greenhill Road Edgemere, Maryland 21219 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Gdns. of Faith Cem. 9/8/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222

Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Apprendiate Cause (Final) Approximate Interval Between mmediate Cause (Final Onset and Death Failure Respiratory disease or condition Hous resulting in death) Due to (or as a consequence of) Preumonia week Sequentially list conditions, if any learning immediate cause. Enter Underlying Cause (Disease or injury Baderial Meningits weeks that initiated events resulting in death) Last Due to (or as a consequence of):

**Physician** /Medical Examiner

attending physician

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

28a-f shov

ò

items 23a

0

'natural",

marked other than

9

Item 2

permit. Pages 1
Department of Hi
Important: If Iter
any Injury or oth

1 and 2 should be

the Medical

Examiner must be notified

Director

Funeral

þ

Completed

Be

ဂ္

23a

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

þ

Completed

Be ဂ္

Certification:

Medical

State Registrar

use as the burial-tran for

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been signed by the a should be detached certificate has been page 2 funeral director. filled in by the To the Hospital within 24 hours a

	d							_		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3   Ectopic 5  Other (s						23d. Date o Month		Year
Part II. Other significant conditions of	ontributing to death but not resulting in th	ne underlyin	g cau	ise given	in Part I.		23e. Did tobacco	use contribu		use of death?
							24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prio dea	r to completic	ndings available ion of cause of
25. Was case referred to medical examiner?				26.	. Place of Dea	ith (C	check only one)			
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpa	tient 3 🗆 🗅	OOA	Other: 4	L □ Nursing F	lome	5 Residence	6 ☐ Other (	Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim			Injury at Work? 1  Yes	2 🗆 No		d. Describe how inju	ury occurred		
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, facto	ry, of	fice		281	Location (Street a City or Town, State	and Number (	or Rural Rout	e Number,
29a. Certifier 1 ☐ Certifying Ph (check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	eath occurred r investigation	datt	he time, o	date and place on, death occ	e, and urred	d due to the cause( at the time, date a	s) and manne nd place, and	er as stated.	Pause(s)
29b. Signature and title of certifier		. 29	c. Lic	cense nur	mber		29d. Da	ate signed (N	fonth. Dav. Ye	ear)

RES-000

September 4, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

m.0

YANG

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death onth Physician/ 1437M Richard Eugene Merryman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medial Center Glen Burnie 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign July 3, 1 🗶 M 2 🗆 F Days Hours Director Maryland <u>214-40-2273</u> 69 Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant! If item 27 is marked other than "natural", or items 23a or 28a-f shour y or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1212 Odenton Rd; Apt 324 21113 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. white Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) truck driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Earl Merryman Francis Leadore Knaub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 188 Hickerson Rd; Manchester, TN 37355 Eileen Alley - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signal re Euneral Service Ronal State Anatomy Board 22. Name and Address of Facility des Director 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of mach line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year signed by the a 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate Yes 2 1 ☐ Yes 2 ☐ No director, æ Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

se of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For	State of Ma					lental Hygi	_		
			State     Registrar      Decedent's Name (First, Middle, La	204)		Certificat	e of Dear	th		eg. N201	1 28867	
	Physicia Media		Rita	Treadv	we11	Miner	•		2. Date of Death Month September		3. Time of Death 011 5:53 A M	Л
-5,	Examir		4a. Facility Name (if not institution, giv				Town, or Locat		<u>Вер<b>с</b>е</u> пь	4c. County		
- Samuel	Francis		Gilchrist  5. Social Security Number 6.		(In yrs. last birti	T If I Indo	OWSON	nder 24 Hrs.		Ba	ltimore	
	Funeral Director		045 06 4000	1 □ M 2 X F		Months Yrs.	Days Hou		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)	ח
	nd now	Ļ	Usual Residence of Decedent  10a. State 10b. County		33 10c. City, Town				Nov. 17	,19//	Maryland	
	Aarylar 8a-f sl tifled	Funeral Director	Maryland Baltimo		-	kesville	2				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	a or 2 be no	٥	10e. Street and Number		7.4	10f. Zip			10	Og. Citizen of W	hat Country?	_
	th with ms 23 must	ıner	724 Howard Road				21208			U.S	.A.	
9	er dea or ite miner	y Fu	11. Marital Status 1 ☐ Never Married 2 🎇 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 XN	rer in U.S. Jo	13. Was Deced	lent of Hispanic ify Cuban, Mex	origin? (Spec kican, Puerto F	cify Yes or No- Rican, etc.)		- American Indian, k, White, etc.	
003	urs afi tural", al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 🗆 Yes	2 X No S <i>p</i> e	ecify:		Specify:	White	
21215-0036	72 ho in "nai Medici	Completed by	15. Decedent's i (Specify only highest g.	rade completed)		Decedent's Usua (Give kind of wor life. DO NOT use	k done during i	most of workin	ng 1	6b. Kind of Bus	siness/Industry	
212	withir giene ser tha		Elementary/Secondary (0-12)	College (1-4 or 5+		gional D		of Sa	les	Hotel I	Industry	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	Donton	Treac	1 <sub>1</sub> 1 1 1	18. N	Nother's Name	(First, Middle, Ma		euci	
aryl	ind Me s mark umativ		Huey  19a. Informant's Name/Relationship (	Benten Type, Print)			(Street and Nu		Route Number, C			
Σ	nd 2 sl ealth a m 27 is		Patrick K. Miner	Husband		24 Howar			ville, M			
ore	ge 1 a nt of H : If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	cemeter	Disposition (Namy, crematory or o	ther place)	1			City or Town, State	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot	1	4 Donation 5 Other (Special Service Liven	*	Hillto	p Servi				Towson	Maryland al Home, Inc.	_
m	Der any	ŀ		yan		1050	York Ro	ad To	owson, M	aryland	21204	-
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between			
***	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Bru	222	ancer					Onset and Death	4
1 sand	Examiner		Due to (or as a consequence of):  Sequentially list conditions,  b.									
	d sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence o	f):					10	$\neg$
	be executed sician and burial-transi	Exar	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									-
		lical		d								
3876	ertificat ling ph	/Mec	IF FEMALE:	00.16							White and the	7
Box 6876	ath ce attend 1 for us	ician	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti	Fetal death	3 Ectopic p				23d. Date	of delivery th Day Year	1
о В	the de by the tachec	Physician/Med	9 Unknown	9 Unknown								_
, P.O.	requires that the death certificate been signed by the attending phy should be detached for use as the	र्व	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlyin <b>g</b> c	ause given in P	art I.	23e. Did toba	1.	oute to the cause of death?	
ords	/ requii	Completed							24a. Was an	7	B ☐ Probably 4 ☐ Unknown  Breautopsy findings available	1
3ec	rsician: The law r s certificate has b director, page 2 s	mo.							autopsy performe	pr d? de	ior to completion of cause of eath?  Yes 2 No	
tal	cian: 7 ertifica ector, p		25. Was case referred to medical examiner?	f -			26. Place of I	Death (Check o	1 Yes 2	NO	res 2 - No	
Ę.	Physi this c	유	1 Yes 2 No 27. Manner of Death	Hospital:  1  Inpatient  28a. Date of injury	t 2 ER/Out	patient 3 DO					(Specify) Nospia	
o uc	ath. r: After re fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Y		jury M	lc. Injury at work? 1  Yes 2		3d. Describe how	injury occurred		
Division of Vital Records,	or Atte fter de irecto in by tf	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury building, etc. (		m, street, factory,	office	28	Bf. Location (Stree		or Rural Route Number,	٦
۵	spital of cours a seral D		29a. Certifier 1 Certifying Physics	sician: To the best of my	v knowledge d	eath occurred at	the time, date of	and place and		,		4
:	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours. The the within 24 hours been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L. Medical Exam)	ner: On the basis of exar se Practitioner: To the b	mination and/or	investigation, in m	v opinion deat	h occurred at th	ne time date and i	place and due t	o the causeo(s) and manner states	ed.
	Norith Cool		29b. Signature and title of certifier				License numbe		290	d. Date si <b>g</b> ned (	Month, Day, Year)	$\exists$
		-	30. Name and address of person who o		th (Item 23a) /Ti	(ne Print)	レフひ	70 >		ry rem	no 1/2011	4
7			AMON 1 CA	thrus u	ND E	2701 N	1 Char	eles s	F TON	son v	no	
	State Registra	~	31. Date filed (Month, Day, Year)	32. Praistrar's	Signature	bare	ī	-				$\exists$
DHM			<del>CFP 1 2 2</del>	377 Jenous	A. A.	garre						

ORIGINAL

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

31. Date filed (Month, Day, Year)

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223 Registrar's Signature

and and a Type of Printing Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Yelizayeta Meyerson-Nosova 2. Date of Death 09/06/2011 Year 3:40 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. (Month, Day, Year) 213-37-6815 1 □ M 2 🛛 F 09/18/1918 UKRAINE 10b. County 10c. City, Town or Location 10d, Inside City Limits MD N/A 1X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 FORDS LANE, #324 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 X Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) CHIEF ENGINEER **METALLURGY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL MEYERSON NADEZHDA NOSOVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SERGEY FERT/SON JONATHANS COURT, COCKEYSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/09/2011 BALTIMORE, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final com disease or condition resulting in death) Sequentially list conditions, rany, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cauces Due to (or as a consequence of): Hordla7 resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Physician/ Medical **Examiner** Examine burial-tra physician The law requires that the death certificate be

the use as

been signed by

After this certificate

Director:

Funeral

within 2

Hospital or Attending Physician;

Physician/

Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f show

ò

"natural"

and Mental Hygiene.

I is marked other than "natur

item 27 i

Department of I Important: If it any injury or of once.

must be notified at

Director

Funeral

by

Completed

Be

ဂ

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician/Medical Completed by Certificate:

Medical

29b. Signature and title of

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R

32. Registrar's Signature

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown	Month Day Year							
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Pa	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown							
		24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No							
25. Was case referred to me examiner?	26. Place of De	26. Place of Death (Check only one)							
1 Yes 2 Who	Hospital: 1 ☐ Inpatient 2 XX R/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Mann of Death  1 Natural 5 Pending 2 Accident Investigati		28d. Describe how injury occurred ☐ No							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	280 Place of Injuny - At home form street feeten, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 \(\sumeq\) Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date ar niner: On the basis of examination and/or investigation, in my opinion, death urse Practitioner: To the best of my knowledge, death occurred at the time, c	occurred at the time, date and place, and due to the cause(s) and manner state							

20059228

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

11-06457 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stephen Eric Nixon 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0901 hrs **Medical Examiner** August 27, 2011 Stephen Eric Nixon 4a. Fecility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death 2210 Allendale Road Apt. 2 **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Linder 1 Year | If Under 24Hrs **Funeral** Months Davs Hours Maryland Director Sept 17, 1947 1XM 2 F 63 216-52-3252 Yrs Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No 28a-f show Baltimore MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 2210 Allendale Rd. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes If Yes. Give Year 1 Yes 2 X No specify: Specify: black 3 Widowed 4 X Divorced à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4 or 5+) Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Virginia Davis Lewis Clements Nixon, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3513 Melody Ln; Baltimore, MD 21244 Lisa Hudley - niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State Itimore, Department of Healinportant: If ite crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 21. Signature of Funeral Service Licen 22. Name and Address of Facility State Anatomy Board Ronald irector 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or de that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical by the attending physician a ached for use as the burial -UNPENDED **AMENDED** IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Dav past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 ✓ No 3 Probably 4 Unknown certificate has been sign rector, page 2 should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? 1 Yes funeral director, page Yes 2 V No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical å Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗹 Other Scene 2 ER/Outpatient 3 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural 1 Yes 2 No Pending the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 29a. Certifier 1 Certifying Physician: For the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 27, 2011 30. Name and address of person who completed cause of death (Item 23a) OCME Deputy Chief Medical Examiner Mary G. Ripple MD 900 W. Baltimore Street, Baltimore, MD 21223 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Caon owsk dmuna orember 6 0207 /Medical 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-34-1101 1X M 2 □ F Months Days Hours Director 8,1936 Maryland Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. Count 10c. City, Town or Location or 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f sho amy Injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2√2 No MD Baltimore <u>Dundalk</u> 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 8187 Park Haven Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2\ No Specify: 3 Widowed 4 Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Painter Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unkn. Be Walter Ogonowski Constance မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan E. Ogonowski(Wife) 8187 Park Haven Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Molly Hill Mem. Gdns. 9/9/2011 4 Donation 5 Other (Specify) Middle River, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm **Physician** Lardior es araton Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner exacerbatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal dea 3 🗌 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) detached 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No S Rrobably 4 🗌 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has k 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 ☐ Accident 1 Yes 2 No 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

n by the funeral 24 hours after death. filled within 24 ho

To the Fune

completely f

the

Sur

Registrar

stephanie State

29a. Certifier

(check only one)

29b. Signature and title of certifier

Medical

Nothell

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

September 6, 2011

31. Date filed (Month, Day, Year) SEP 1 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RESCOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September <sup>1y</sup>5, Gary E. Philyaw 2011 9:15 Ам Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Center Prince George's Bowie 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. **Director** 216-64-5343 57 Washington, DC 1953 Usual Residence of Decedent show 10a, State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Prince George's 1XXYes 2 No Bowie ò 10e Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral 23a 3512 Madonna Lane 20715 USA items ? Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or ite 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) if Health and Meniam of the intermed other the other traumatic event, the Marketing Sales & Support Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Barry Philyaw Audrey June Twilley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Der artment of Health Important: If item 27 any injury or other tr Pam Philyaw/ Wife 3512 Madonna Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9/11/2011 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home alle 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and weat Mocardia disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events burial-trans resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Pregnant at time of death Month Day Yes 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy performed death? certificate Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referr medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one) 29b. Signature and title of certifie

Date filed (Month! D

30. Name and address of person who

avance

completed cause of death (Item 23a) (Type, Print)

29c. License number

31602

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28873 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 03 Sep knoe Physician/ Parrish Gwondolyn 0030 AM 2011 Medical Pannish 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner NA City Baltimore Hospital of Ballimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Country) MD **Funeral** 1 - M 2 XF 215.64.9031 Director Usual Residence of Decedent known as Ctwendown 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltinuore must be notified MD 1 Yes 2 No )WIMQS 10g. Citizen of What Country? ò 10e. Street and Number or items 23a Funeral Doe USA 414 Meadow 21117 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ith and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner I Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: RIGCK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Baltimore Count 2th grade Be 17) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles E. Parrish, Sr. Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Garden Avenue Baltimore, MD 21207 Sister Department of Health a Important: If item 27 is any injury or other tra Kiddick 363 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Windsor Mill, MD 10/201 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Funcial services 21. Signature of Funeral Service Licensee Vallahn 22. Name and Address of Facility Road Ra uda Ustown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final henor Physician/ day disease or condition resulting in death) Medical **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due that r as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last ending physician ause as the burial-Physician/Medical Box 68760 signed by the attending d be detached for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 1 ☐ Yes 2 ₺ 9 ☐ Unknown vision of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown After this certificate has been signaled funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and September, 03, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sinci trospital of MBBS PRIYANKA 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28874 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PERTEE JOYCE sept O3 Day 5 20 PM 2011 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 219-40-4249 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDBALTIMORE 1 ❤Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4NDRAUS 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 Yes 2 KNo Specify. BLACK 3 X Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) LEITH WALK College (1-4 or 5+) Elementary/Seconday (0-12) ELEMENTARY SCHOOL EDUCATOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LERDY JOHNSON, SR. WILLIE LILLIAN JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE H. PERTEE (DAUGHTER 11410 Snow DROP CT. UPPER MARLBORD, MO. 20144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date BACTIMORE, MD GREENMOUNT CREMATORY Donation 5 22. Name and Address of Facility VAUGHN GREENE RUNERAL SCVS Signature of Funeral Servi ROAD. BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UMCAL HERMI ATION disease or condition resulting in death) Due to (or as a consequence of) INTRA CEREBRAL HAMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on HYPERTENSION Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Diabetes stroke 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1. Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number,

Exami resulting in death) Last physician a s the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Hypertension Completed Vital Hospital or Attending Physician; 25. Was case referred to medical Be 10 1 Yes After this Division of 27. Manner of Death Certificate: 1 Natural Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, years occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Banpuant MBBS RES 000 Sept 03, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

State

Physician/

Medical

Director

Funeral

ρ

Be

**Examiner** 

**Funeral** 

Director

show notified at

28a-f

must be r

should be file and Mental F is marked of

permit. Page 1 and 2 should be f. Department of Health and Menta' Important: If item 27 is marked any injury or other traumatic ev

Ph sician/

Medical

**Examiner** 

Maryland 21215-0036

Baltimore,

S. A. KOLGE

31. Date filed (Month, Day, Year,

LOCH RAVANBLUD, BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Poteat Year Physician/ Margaret Α. sent 1325pm 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE TUIAL N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Hours May 2,1948 Maryland Director 63 218-54-1924 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD N/A 1X Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 United States 145 North Luzerne Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give X☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) Blue Cross & Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Clerk Blue Sheild 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elizabeth V. Grafton Arthur E. Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21075 6636 Washington Blvd. #117 Mrs. Alexis Slabaugh (Daughter) Elkridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9/10/2011 Glen Haven Cemetery Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the shock, or healt 1 Approximate Interval Between Immediate Cause (Final Onset and Death ₽nysician/ liver metastasi Breast With cancer disease or condition YEAR Medical resulting in death) Examiner quantially list conditio Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year g Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No The 1 🗌 Yes 2 🗆 No certificate To the Hospital or Attending Physician: Be 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Director: After thi 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) , MD D72450 Sept. 7, 2011

State Registrar

GARET

Z FR

900 S. LATON AVENUE BALTIMORE, MD-21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

DURGA DHOJ ADHIKARI

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			A COL	partment of Health and Mertificate of Death	ental Hygier		28876
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  LILLIAN  PETR		2. Date of Death	Day 2011	3. Time of Death
di Para	Examir Funeral Director		4a. Fecility Name (If not institution, give street and number)  FutureCare Canton Har. Nursing Home  5. Social Security Number  6. Sex  1 M 2XF 96  Yrs.	Months Days Hours Min.		O Diet	imore City  place (State or Foreign  ryland
		tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or L   MD   N/A		Jan. 75 I	715 1141	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 13s or 28s	al Director	10e. Street and Number 800 S. Robinson Street	10f. Zip Code 21224	_	Citizen of What Co	
980	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show to Mudical Examirer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Married   Tyes 2 Married   Tyes 2 Married   Tyes 2 Married   Tyes 3 Married   Tyes 3 Married   Tyes 4 Marr	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
Maryland 21215-0036	77 (2 4 2	Completed	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired) LTSES Aide	ng	Kind of Business/	
rland	of Hea item	To Be C	17. Father's Name (First, Middle, Last)  Frederick Emala	18. Mother's Name Rose	(First, Middle, Maid Pural	en Sumame)	
		•		ling Address <i>(Street and Number or Rura</i> 39 Slater Avenue B			
Baltimore,				position (Name of Dematory or other place)  nislaus Cem. 9/9/		Location - City or altimore,	Town, State Maryland
Balti	permit. Page Department of Importent: If any injury or once.			22. Name and Address of Facility Ouda-Ruck Funeral Ho 1922 Wise Ave. Dunda			
	Physician /Medical		23a Part 1. Enter the disease or complications that ceused the death. Do not er shock, or heart failus. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death
8760,	certificate be executed ding physician and see as the burial-transit	Ilcat Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):				
O. Box 6	death certif e attending id for use a	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	es be	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacc		the cause of death?
Vital Record	₹ 0 0	e Completed			24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of
Division of Vit	or Attending Physician: The la after death. Director, After this certificate has in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner?  1		(Check only one) ne 5 Residence 88d. Describe how in		rify)
Dİ <u>X</u> i	tel or Att rs after d el Direct ed in by t	Certiffe	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
	To the Hospitel or Attenwithin 24 hours after deating to the Funerel Director; completely filled in by the	Medical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, dear control on the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date a	ind place, and due	to the cause(s)
)	1 × ×	2	29b. Signature And title of certifier	29c. License number  D67220	29d. C	Poste signed (Month	n, Day, Year)
	H gr		30 Name and address of person who completed cause of death (Item 23a) Bype,	em Ave. Ba	Stimore	Z, MD	•
	Sta Registr		SEP 1 2 2011 32. Registrar's Signature.	arke		/	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#23a, pt1,23e, perPHYS, G919,971420 IT, ws

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9. Physician/ September 2011 8:15 AM Palmer Johnnie Robert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner <u>Baltimore</u> 1509 Barkley Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 X M 2 □ F Months Hours Min. (Month, Day, Year) 8/23/1926 Director 254-30-8603 85 Georgia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No Baltimore Essex Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1509 Barkley Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2X Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1944 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates 1946 White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Steel Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jimmy George Palmer Dessie Peeler Warlic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Barkley Avenue Maryland 21221 Helen Rebecca Palmer (Wife) Essex, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/13/2011 Bayview Crematory Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility any in Bruzdzinski Funeral Hon 1407 Old Fastern Avenue Home Maryland 21221 23a. Str. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Small cell lung cancer Approximate Interval Between answere kst Immediate Cause (Final Cancer und Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence a) Examiner Sequentially list conditions ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day 4 Pregnant Pregnant at time of death 1 Yes 2 9 Unknown 2 No has been signed by the age 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2 **X** No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 
 □ Acciden

 □ Suicide
 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Jo. M. D G 1ao 7703 iman Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 SQUARE DRIVE MD FRANKLIN 15 ALT IMORE 31. Date filed (Month, Day, Year) 32. Régistrar's Signatur State And white Registrar

DHMH 17 Rev 1/2001

Known

atient

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2011 5:30 Karin Tracy Roesle Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Severna Park Anne Arundel 605 Brownstone Dr. If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Hours Min. July 23, Year 982 VTT inia Director 29 224-41-2500 Usual Residence of Decedent show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Severna Park MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 605 Brownstone Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) auditor accounting Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles J. Roesle Jr. Carol Schlechten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Roesle Jr - father 605 Brownstone Dr; Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pirector 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest should or heart failure. List only one cause on each line. Interval Between High grade astrocy toma Immediate Cause (Final disease or condition resulting in death) (Guain tumor Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence oi). sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day detached 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HIO acute lymphocytic *leukemia* 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 입 1 Tes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending After 1 Natural 2 Accider 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director; Al Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eloud, U.D. Annapolis, Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stravt E. Selonick, M.O. 20 2003 medical Parkway

DHMH 17 Rev 7/2009

State

Registrar

vavt

31. Date filed (Month, Day, Year) SEP 12

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

barke

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28880 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Tear Richards September 12:50 P Martha D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Renaissance Gardens If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 XF 304-16-6838 91 March, 63y, 1920 Indiana Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director must be notified 28a-f 1 Yes 2 X No Silver Spring Maryland Montgomery ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a USA 3160 Gracefield Rd. 20904 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give "natural", 3 □Xwidowed 4 □ Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical!" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martha Bul1 Harry Dilks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 15122 Players Way, Glenwood, Maryland 21738 David Richards— SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crematory Sept. 9, 2011 Glen Burnie, Maryland permit. 21. Signature of Funeral Sen 22. Name and Address of Facility Fleck Funeral Home, INC. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 10 Feat Seath Immediate Cause (Final Advanced Alzheimer's Disease Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ģ Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital or thin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1586le mo

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

Eileen Germell, 3160 Gracefields Road, Silver Spring, Maryland 20904

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.pt.lb.,27,28a-f,per me, g932 10-12-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar 28881 Reg. 2.0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 4, 2011 Physician/ 03:03A M Rampersad Medical GILChrist Hospice Care, Inc. **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Facility Columbia Howard 8. Date of Birth (Month, Day, Ye August 17, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Trinidad 1 **X** M 2 □ F Days Hours Months Min. 64 217-15-1891 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4812 Lexington Avenue 20705 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married "natural", or ģ 1 Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than rould be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 Building Engineer Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Lutchmi-Persad Rampersad Mahadaya Ganesh Singh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S and 2 s Health 27 David Rampersad/Son 8607 Slate Hill Circle, Frederick, Maryland 21704 pernit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

Burial 2 

Cremation 3 

Removal from State west Arundel September 8, 2011 4 ☐ Donation 5 ☐ Other (Specify) Crematory Odenton, Maryland 21. Signature of Funeral Service icensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Etone M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ conflications of gangrenous disease or condition resulting in death) DZT 20 Medical r as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Right Toe Injury Se wentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day signed by the a 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 [X No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? the funeral director, page <u>Olisias</u>c 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending subject dropped piece of wood on right toe 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4812 Lexington Ave. Beltsville, MD. work' fd Nov, 2010 unknown M 1 🗌 Yes 2 🙀 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) enos COMMO 31. Date filed (Month,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 28882 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death sep 2:39AM Paris Rose 0 2011 Joseph or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, Baltimore HOSDHail Agnes If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1928 West Virginia 8. Date of Birth (Month, Day, April 5, Social Security Number 7. Age (In yrs. last birthday) 1**∑** M 2□ F Months 235-48-2004 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Baltimore 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2428 Alma Rd. 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Navy 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Assembly Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Η. Rose Nora Richard Moya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Rose (Wife) 2428 Alma Rd., Baltimore, MD 21227 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 9/12/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1—Farer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? tension, Dementio 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No

**Physician** /Medical Examiner Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transi been signed by the should be detached icate has been s , page 2 should

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

Director

Funeral

\$

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it e Mexical Examiner must be notified at

Department of Health a Important: If item 27 is any injury or other trau

Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ntt: If item 27 is marked other than "natural", or items 23s

Baltimore, Maryland 21215-0036

After this certificate the Hospital or Attending Physician: funeral ieral Director; A death

Completed by Be P

Physician/Medical Certification:

Medical

State

Exami

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy 1 □ Ýes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

aten Avenue, Baltimore MD, 21229

and manner stated.

after

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28883 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O Month Physician/ HARRY DAVID REEDY 0.3 2011 11:55 PM Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1260 Rock Hill Rd Anne Arundel Pasadena Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA 8. Date of Birth 1 2 3 1 7. Age (In vrs. last birthday) **Funeral** Days 1 🗷 M 2 🗆 F Min. 178 36 0561 66 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 1260 Rock Hill U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1  $\times$  Yes 2  $\square$  No 1963 If Yes, Give Year or Dates. 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 han "natural", o 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me National Elementary/Seconday (0-12) College (1-4 or 5+) Security Research Analyst Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Fenstermacher Samuel Reedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1260 Rock Hill Rd Pasadena, MD Janet Reedv - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Bayview Crematory 9/6/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ myo (grdia Intarction disease or condition Medical resulting in death) **Examiner** 4000 ronary disease Sequentially list conditions, cause. Enter Underlying Exami 1001 Cause (Disease or iinjury that initiated events and Due to (or as a consequence or resulting in death) Last physician a s the burial-Physician/Medical years that the death certificate be 31C Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ō in the past 12 months? Dav Pregnant at time of death Yes 2 No the 9 I Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No ☐ Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After templeted filled in by the funera 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 52008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 N. Caroline St. Bultimore MD21287 rokspow? Gregor 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5 per fh. 9920 10-28-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0 RGC Medical 4a. Facility Name (if not institution, give street and numb **Examiner** b. City, Town, or Location of Death Baltimore Seasons Hospice Randallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months (Month, Day, Year) **Director** 1 🏝 M 2 🗆 F Yrs 8/25/1946 65 MD or 28a-f show 10c. City. Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 599 Elyse Ct. 21784 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or 1 Never Married 2 XX Married 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. unknown 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mechanical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gordon Joffre Shriver Edna Constance Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minna Shriver/Wife 599 Elyse Ct., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl once, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 9/7/2011 Winfield, MD uneral Service Licensee Signature of <sup>22</sup> Barrier-Ծմեզար Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on ne late Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has performed Yes 2 2 🗌 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 to Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sent embour Year 2011 12: 21:12 M Virginia Ruth Singleton Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 屎 F Days Months Hours January 12, 1929 82 West **Director** <sup>'</sup>Virginia 224-32-4512 Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Anne Arundel Maryland Severn ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 1124 Reece Road 21144 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 'natural", or ð 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental F ဂ္ William Perkins Nannie Johnson Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Nathan Singleton/Husband 1124 Reece Road, Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematery or other place)
Crest Lawn
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) September 14 2011 Marriottsville,Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licens MO1386 he disease, or complications that caused art failure. List only one cause on each line. 23a. Part 1. Enter h shock, or heart That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, Examine Due to (or as a co if a y, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted. Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: been signed by the attendir should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown Unknown <u>P</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director. After this certificate be completed filled in by the funeral director, page 1 Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 은 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending work? 1 🔲 Yes 1 Natural injury 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Ny se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar d title of certifier 29d. Date signed (Morsth. Dav. Year) 048006 erson who completed cause of death (Item 23a) (Type, Print) Burn Huspital WUSU BOA

State Registrar Division of Vital Records, P.O. Box 68760

		Ple	ase Type or P	rint in	Black I	ndelible Inl	k. Ensu	re All Copie	s Are	Legible		
		For State Registrar	State of	Marylar		artment of F rtificate of L		nd Mental Hy	/giene Reg. No.	2011	288	86
Physicia Medic		1. Decedent's Name (First, Midda	Donald	Lee	e l	Smith		2. Date of D Month Septe		3,20	3. Time of 1 1 1 : 0 9	
Examin	er	4a. Facility Name (if not institution Greater Balt:		•	Cente	4b. City, Town, or		Death		County of Deat		
Funeral Director		5. Social Security Number 212-36-9338	6. Sex 7.	Age (In yrs 75	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi	irth  av. Year) 29 <b>,</b> 19	9. Bir Co Ker	thplace (State or untry) ntucky	Foreign
yland -f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City	•
h the Ma a or 28a be notifi	Funeral Director	MD 10e. Street and Number	Baltimore			10f. Zip Code	Dunda	1k	10g. Citi	izen of What Co	1 \(\superstack Yes\)	2 23 NO
th with ms 23 must	iner	7901 Trappe R								ited St		
s after deat al", or iter Examiner	þ	Narital Status     Never Married 2 ☐ Ma     Widowed 4 ☐ Divorce	If Van Citta	s? <b>K</b> No	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No		n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ame Black, White Specify:		
hour natur dical	olete		ent's Education			dent's Usual Occup		fadda-	16b. Ki	ind of Business	Industry	
J within 72 ygiene. her than " tt, the Mec	Be Completed	Elementary/Seconday (0-12) 12 Years	College (1-4 of 4 Years	or 5+)	ilfe. E	kind of work done of DO NOT use retired) rinter	uring most o	r working		ommunity Colleges f Baltimore Co.		}S
ntal H ed ot ever	To B	17. Father's Name (First, Middle,	Last)					s Name (First, Middle		Surname)		
ould bould bound bound bound bound we want		Henry Smith  19a. Informant's Name/Relations	ship (Type Print)		10b Maili	ng Addrass (Street		essie Albr or Rural Route Numb		Town State 7ii	n Codel	
d 2 sh alth ar 27 is		Janet Pope	(Sister)		1			ad Middl				21220
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. It has been so is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		ate (	cemetery, cre	osition (Name of matory or other plac of Faith		Date /9/2011		ocation - City or	Town, State  Maryla	nd
permit. Departi Import any inj		21. Signature of Funeral Service	Licensee		2	2. Name and Addres	s of Facility Funer	al Home o	f Dun	ndalk, I	Inc.	
40200		23a Part 1 Enter the disease of	r complications that caus	sed the deal		/922 Wise	Ave.	Dundalk,	_Mary	land ?	21222 Approximate	
Priysiciari Medical	8 1	23a art 1. Enter the disease, o shock, or heart failure List Immediate Cause (Find disease or condition resulting in death)	only one cause on each  a. Du A (or a	iline.	uence of):	injar	ction	r			Interval Betw Onset at D	veen Death
Examiner	ايا	Sequentially list conditions,	b UH	4/3/3	Hemi	e Shor	$\mathcal{U}_{\underline{}}$				<24h	V
be executed /sician and e burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Henry Due to (or a	conseq what as a conseq	uence of):	sound	Va	chesto	ny	ste	<24h	<u>د</u>
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	h 2 🗀 Feta it at time of	aldeath 3 [	☐ Ectopic pregnanc☐ Other (specify)	у			23d. Date of de Month	•	'ear
ires that signed t		Part II. Other significant conditi	ons contributing to death		sulting in the	underlying cause giv	en in Part I.			1/	the cause of derobably $4 \square $ L	
he law requ te has beer age 2 shoul	Completed by	hyphosibl	rosis					24a. Was auto perl	s an opsy formed	prior to	topsy findings a completion of ca	
ian: T		25. Was case referred to medical examiner?	7			26. Pla	ace of Death	(Check only one)	2 🗆 NO		3 Z 🗆 NO	
hysic his ce al direc	은	1 Tes 2 V No			1	nt 3 🗆 DCA Othe	r: 4 🗌 Nurs	ing Home 5 🗆 Res	idence 6	Other (Spec	eify)	
ling P. T. After t funera	ate:	27. Manny of Death  1 Natural 5 Pendii	ilg .	njury Day, Year)	28b. Time o injury	work	?	28d. Describe	how injury	occurred		
Il or Attence after deatl Director: ,	Certificate:	2  Accident Investi 3  Suicide 6  Could 4  Homicide detern	nined 28e. Place of I	Injury - At ho etc. (Specify		M 1 L	Yes 2 ☐ N	28f. Location	(Street and wn, State)		ral Route Numbe	ər,
ne Hospita n 24 hours ne Funeral pleted fille	Medical	(Check 2 Medical I	g Physician: To the best Examiner: On the basis o g Nurse Practioner: To the	f examinatio	n and/or inves	tigation, in my opinio	n, death occu	urred at the time, date	and place,	and due to the	cause(s) and mar	ner state
To the complete compl		29b. Signature and title of certifie	porul	M	m	29c. License	number 3	3	29d. Date	e signed (Monti	2011	
2 24		30. Name and address of person		f death (litem	n 23a) (Type, I	Print) N Cha	rles	treel	6	allin	ne 2	120
Stat	C	31. Date filed (Month, Day, Year)		strar's Signa	ture 6	aked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 12abeth 238 Medical 4b City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Balhmare NIA neversity Med If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours 12/6/1964 017-44-4339 Massachusetts **Director** 46 Yrs. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Middletown 1 Yes 2 X No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 6501 Morningside Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 and Mental Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Director Finance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Allan J. Royal Barbara Ann Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collin Schaffer / Husband 6501 Morningside Court Middletown, MD 21769 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv. Corp. 9/7/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition www Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the a d be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Coplered 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has b lirector, page 2 s performed? Yes 2 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No JO 1 ∰npatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after deat Director, 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certific 1🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature an d title Af 29c. License number 29d. Date signed (Month. Day, Year) no completed cause of death (Item 23a) (Type, Print) and address of

State Registrar

DHMH 17 Rev 7/2009

Year)

32.

mo

lhm ove

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Joseph D. Spadaro Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) UNK 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min July 29, 219-30-7102 75 Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21206 6116 Belair Rd. 12. Was Decedent Ever in U.S. UNK Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 Married þ 2 🗌 No white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Loch Raven Blvd; Baltimore, MD 21239 19a. Informant's Name/Relationship (Type, Print) Department of Health au Important: If item 27 is any injury or other trans Good Samaritan Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State cemetery, crematory or other place, S. Director 22. Name and Address of Facility State Anatomy Board Ronald 655 W. Baltimore St; Baltimore, MD 21201 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last End Stree and burial-trar Due to (or as a consequence of attending physician Physician/Medical The law requires that the death certificate be Failu Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year per. the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 tonknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed? certificate 2 - No 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Redistrar's Signature

31. Date filed (Month, Day, Year,

D00626

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	State of Maryland		artment of Hea tificate of Dea			201	1 28889
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	San Gara	LI.	C.		2. Date of Dea Month	Reg. No. th Day Yea	3. Time of Death
	Medi Exami		4a. Facility Name (if not institution give stre	ot and number)	11	4b. City, Town, or Loca	ation of Death	9	4c. County of D	7:50 A M
-	Funeral	r		Tes 7. Age (In yrs. Igs	st bjrthday)		MOY Q Inder 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	7. Age (In yrs. las	3 Yrs.	Months Days Ho	ours Min.	(Manth, Day	19918	Country) MD
	aryland a-f shov fied at	Director	10a. State 10b. County	10c <u>. City</u> ,	Town or Loc					10d. Inside City Limits 1 Yes 2 □ No
	th the Misa or 28	al Dire	10e. Street and Number	TO THE WAY	Delling	10f. Zip Code	21		10g. Citizen of What	
	leath wil	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S.	13. W	/as Decedent of Hispan	ic Origin? (Spec	cify Yes or No-	14. Race - A	merican Indian,
920	s after or ral", or Examin	ğ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.		Yes, specify Cuban, Me		Rican, etc.)	Black, W	hite, etc.
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade o	ompleted)	(Give ki	ent's Usual Occupation and of work done during NOT use retired)	most of workir	ng	16b. Kind of Busine	ss industry
	ed within Hygiene. other tha	Be Cor		College (1-4 or 5+)	Bo	ler Opera	ctor		BaltiMore	City Schools
Maryland	ould be filed d Mental Hy marked oth matic event	To E	17. Father's Name (First, Middle, Last) (NEVNAY)	yith		18.	Mother's Name	(First, Middle, M	Maiden Surname)	,
	shou and is n		19a. Informant's Name/Relationship (Type,	Brother	19b. Mailing	Address (Street and N	lumbe. Rural + Aven		City or Town, State,	Zin Code)
altimore,	o = to		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Ren	noval from State 20b. Pla	metery, cremi	ition (Name of atory or other place)		ate	20c. Location - City	or Town, State
Baltin	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify) 21. Ignative if Funeral ende Licensee	U Gar	VISON 22.	Name and Address of F	acility	5151	BULLIGS MI	e, MH FIRE
	<u> </u>		23a. Part 1. Enter the disease, or complicat	ions that caused the death.	Do not enter	uhn C. Great the mode of dying, such	ch as cardiac or	respiratory arre	HMOVE, M.	0. 2/229 Approximate
<b>. .</b>	Physician/ Medical		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death)	use on each line.	dis	tructive P				Interval Between Onset and Death
-	Examiner	<u>.</u>	Sequentially list conditions, b.	Due to (or as a consequer	nce of):					
	uted d ansit	amine	cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequen	rida viji					
0	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	that initiated events c resulting in death) Last	Due to (or as a consequen	nce of):					
38760	irtificate ling phy e as the	/Medi	IF FEMALE:					7		
Box 687	death ce ne attenc ed for us	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal o 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
P.O.	that the ned by th detache	y Phy	9 ☐ Unknown  Part II. Other significant conditions contrib		ting in the und	derlying cause given in	Part I.	23e. Did tob	pacco use contribute	to the cause of death?
rds,	requires been sign hould be	eted k						1 □ Ye	es 2 🗆 No 3 🗆	Probably 4 Unknown
Reco	The law ate has the bage 2 s	Jomp						24a. Was ar autops perforr 1 \(\sum \) Yes 2	y prior to ned2 death	autopsy findings available o completion of cause of ? /es 2  No
Division of Vital Records,	rnysician: Irthis certifica		25. Was case referred to medical examiner?  1  Yes 2 No	tal:	2/2	Lau	Death (Check o	only one)		
n of	aing Phy h. After this funeral c		27. Manner of Death 1 Natural 5 □ Pending	1 ☐ Inpatient 2 ☐ EF 8a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury at work?	28		nce 6 Other (Spe w injury occurred	ecity) iAssisted living
VISIO	r Attender fer deat irector.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	M 1 Yes	-		reet and Number or F	Rural Route Number,
ה מ	- 10 T	Medical C	29a. Certifier 1 Certifying Physician	To the best of my knowled	ge, death oc	cured at the time, date	and place, and	due to the caus	cele) and manner as s	stated.
4	o the rivithin 24 To the Fu	— r	(Clieck 2 in Medical Examiner: (	on the basis of examination are ctioner: To the best of my kr	nd/or investia	ation in my opinion dea	th occurred at the date and place,	ne time, date and and due to the	d place, and due to the cause(s) and manner a	e cause(s) and manner stated. as stated.
	> - 0		I Josep Hack	mo		D006119			Pept, 8	
		·	30. Name and address of person who comple	· ·		,	*410	15. M	uson M	D 21204
	State Registra	<b>-</b>	SEP 1 2 2011	32 Registrar's Signatur	-	KI)		- (-10)		<u></u>

DHMH 17 Rev 7/2009

			Pleas	e Type or Pri								e.
			For State	State of M	arylan		artment of I tificate of I		ind Mental		2011	28890
			Registrar  1. Decedent's Name (First, Middle, L	ast)			tinoate or t	Journ	2. Date of	f Death		3. Time of Death
	Physicia Medio		LOUISE	Ç	SOLOM	ON			SEPT	EMBE	ER 7, 201	1 11:10 A M
	Examin	ner	4a. Facility Name (if not institution, g	· ·			4b. City, Town, o		f Death		4c. County of De	
-	Funeral		SUBURBAN HOSPI  5. Social Security Number 6	Sex 7. Ag	e (In yrs. la	st birthday)						irthplace (State or Foreign
	Director		214-22-8376	1 □ M 2 🛛 F	98	Yrs.	Months Days	Hours	Min. 1070	5/1/9	72	MD MD
	and show lat	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryla 28a-f	Director	MD MONTG	OMERY	R	OCKVIL	LE					1 ☐ Yes 2 🛣 No
	th the	alD	10e. Street and Number				10f. Zip Code			109	g. Citizen of What 0	Country?
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	Funeral	6121 MONTROSE  11. Marital Status	12. Was Decedent I	Ever in U.S	. 13. V	208 Vas Decedent of H		in? (Specify Yes or	No-	USA 14. Race - Am	perican Indian
98	fter de , or its amine		1 Never Married 2 Marrie	Armed Forces? 1 □ Yes 2 🛣		li li	Yes, specify Cuba	an, Mexican,	Puerto Rican, etc.		Black, Wh	
21215-0036	ours a ntural"	Completed by	3   Widowed 4 □ Divorced  15. Decedent's	If Yes, Give Year or Dates.								WHITE
215	ון 72 h an "na Medic	mple	(Specify only highest Elementary/Seconday (0-12)		5.1	(Give F	lent's Usual Occup kind of work done ( O NOT use retired)	ation during most :	of working	16	6b. Kind of Busines	s Industry
212	e filed within 72 hours tal Hygiene. ed other than "natur event, the Medical I		12		)+) 	HOM	EMAKER				OWN H	OME
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Las	,					r's Name <i>(Fir</i> st, <i>Mic</i>	idle, Mai		OD GOM
aryl	should be file n and Mental I 7 is marked o raumatic eve	9	SIMON  19a. Informant's Name/Relationship		PENN	19b. Mailin	a Address (Street	ETHEL JACOBSON  Street and Number or Rural Route Number. City or Town, State, Zip Code)				
ž	1 and 2 of Health item 2: other t		SYLVIA ROSENTH	AL/DAUGHTEI	2	I	,		ROCKVILL			
Baltimore, Maryland			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from State	20b. Pl	ace of Dispo	sition (Name of natory or other place	(e)	Date	20	c. Location - City o	or Town, State
Itim	Pa ant ury		4 ☐ Donation 5 ☐ Other (Special Signature of Fuperal Service Co.		,		ACOB ANS R CEMETE		9/09/201	_	BALTIMO	
Ba	permit. Departr Import any inji	- 8	21. Signature of Funding Statistics	>		- 1					N & BROS	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between
-	Physician/	i y	Immediate Cause (Final disease or condition	- a		EUN	NONIA					Onset and Death
· Orman	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):		_	RGAN	Ac	11	
		ner	Sequentially liet conditions, if any, leading to immediate	Due to (or as	a conseque		IFICU	, ,	MOAN	113	, of	
	executed an and rial-transit	Examine	cause. Enter Underlying Cause (Disease or linjury that initiated events	C								
_	o ici	ज्ञ	resulting in death) Last	Due to (or as	a conseque	ence of):						
1260	sician: The law requires that the death certificate k certificate by the attending physicctor, page 2 should be detached for use as the t	Physician/Medic		d								
Box 68760	n certifi ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy death 3	Ectopic pregnanc	ev.			23d. Date of d	elivery
Bo	e deat the at hed fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specify)			_	Month	Day Year
P.O.	that the	by Ph	Part II. Other significant conditions	contributing to death b	ut not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. [	id tobac	cco use contribute	to the cause of death?
ds,	quires en sign		Chronic	obstn	rdi	Ve	Lung	Dis.	elie 1	☐ Yes	2 No 3 □	Probably 4 🗆 Unknown
Division of Vital Records,	law re nas be e 2 sho	Completed							8	Vas an utopsy	prior to	utopsy findings available completion of cause of
l Re	n: The ficate	e Co	25. Was case referred to medical	1			00.50		1 🗆 `	erforme (es 2	do death?	es 2 🗆 No
Vita	ysicia is certi directo	To Be	examiner?	Hospital:	ent 2	R/Outpatien	Oth	er:	sing Home 5 1	Residenc	te 6 🗆 Other (Spe	ecify)
of	ng Phys fter this ineral di		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of inju (Month, Day	ry	28b. Time of injury	28c. Injury	/ at			injury occurred	
sion	uttendi death ctor: A y the fi	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	be 280 Place of Init	ını - At har	no farm etra		Yes 2 I		n /Ctra	st and Number or E	ural Route Number,
Σį	al or A s after il Direct		4 Homicide determine	building, etc	. (Specify)	no, iaim, silo	et, lactory, office			Town, S		urai noute Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate k within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I	Medical	29a. Certifier 1 Certifying Pl	ysician: To the best of niner: On the basis of e	my knowle	edge, death o	ccured at the time	, date and pl	ace, and due to th	e cause(	s) and manner as s	tated. e cause(s) and manner stated.
	o the lathin 2 or the location of the lathin 2 or the lathin 2	Me		urse Practioner: To the				e time, date a		o the ca		s stated.
	F > F 0		1 Arnah	Ruin	is.		Dog	180	84	SE	PIEMBE	R 07 2011
in	J		30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type, P	rint)			0		* 4: 2
1 7	Stat		31. Date filed (Month, Day, Year)	A / C C	M. 9	- 6/	5, MO	NTOO	54 121)	14	OCHUILL	EMU 20852
	Registra		SEP 12	2011	ing.	1. 1	ares					
		-		010		- 4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alfred Milton Samborski 9:10 AM Medical 06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rosedale Baltimore 6. Sex 1 ፟፟፟፟ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8 Date of Birth Months Hours Min Sept 21, Year 1929 Director 219-22-8914 81 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 🔀 No Baltimore Essex MD 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? pe 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b USA 21220 929 Back River Neck Rd. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1948 Black, White, etc. white Completed by 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) maintenance State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Alexandra Weirzbicki ပ Joseph Samborski permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Mildred Mikulski-Cook</u> - friend 323 S. Conklin St; Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Openation 5 ☐ Other (Specify) Director 22. Name and Address of Facility State Anatomy Board Signature 1 - uneral Service Lice 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** mphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🖪 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔁 No 1 Yes Other: ၉ 1 ≤ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🔼 Natural 5 Pending work?
1 Yes 2 No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D 00 68 69 4 29b. Signature and title of certifier

State Registrar

Alfred

Samborski

who completed cause of death (Item 23a) (Type, Print)
LLY M.D.; 9UDO, Franklin Square Dr.; Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28892 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 3, **Physician** Jean May Torbert 2:00 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Riverview Care Center Essex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 13, 1930 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 80 213 28 3667 **Director** Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Baltimore r than "natural", or items 23a or 28a-f sl the Medical Exeminer must be notified Director Essex 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2222 Turkey Point Rd. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 □Yes 2 🗖 If Yes, Give Year or Dates: 2 **X** No P 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: White ⋧ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Clerk Retail other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental is marked Vincent Wood Sr. Carrie Warriner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. William Lloyd Torbert Sr. (Husband) 2222 Turkey Point Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gardens 9/6/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service <sup>22. Name and Address pf Facility</sup> Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate
Interval Between
Onset and Death
Um - Choon 23a. far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Hanana **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Bart I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 □ Yes 2 □ No 3 Probably 4 ₩hknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1NO 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, or Attending within 24 hours a

Baltimore, Maryland 21215-0036

Registrar

() ASBEM 31. Date filed (Month, Year)

29b. Signature and title of certifier

(Check only

709 BASTERN BLVD. 32. Registrar's Signature

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ Month 2011 Carole June Travis 1300 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Peninsula Regional Wicomico Medical 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Jan 25 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Country) Florida Months Director 087-34-3908 66 Usual Residence of Decedent show at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 504 Truitt St. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? 1 🕅 Never Married 2 🗌 Married Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) pizza parlor driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Travis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Bradford - great niece 504 Truitt St; Salisbury, MD 21804 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatu disease or condition resulting in death) Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown P.O. þ signed Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>و</u> | pe o Records, 1 ☐ Yes 2 ☐ No → Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 performed death? certificate Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, after City or Town, State within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one D 63199 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cl 27/11

State Registrar Carrol

32. pgistrar's Signature

Salisbury, MD 2/80

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ει

ugene Wilson		Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H	_		2000
agene Wilson		1-For State Certificate of Death Registrar	_	2011	2889
Physicia Indical Exami		1. Decedent's Name (First, Middle,Last)	2. Date of Death Month [ August 19, 2		3. Time of Death 1800 hrs
) ,*		Eugene Gilbert Wilson  4a. Facility Name (if not institution, give street and number)  Howard County General Hospital  Columbia		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 214-26-1025 1X M 2 F 82 Yrs.	_	Teorgia	thplace (State or In untry)Maryland
rland f show any once.	tor	Usual Residence of Decedent  10a. State			10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	Il Director	10e. Street and Number 303F Willrich Cir. 21050		g. Citizen of What Cour	_
ter death wit ", or items?	/ Funeral	11. Marital Status  1 Never Married  2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 No 1951  3 Widowed  4 Divorced  If Yes, specify Cuban, Mexican, Puerto  If Yes, Specify Cuban, Mexican, Puerto  1 Yes, Specify Cuban, Mexican, Puerto  1 Yes, Specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc. Specify: Whi	can Indian, Black,
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	leted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired to the control of the		16b. Kind of Business/I	ndustry
5-003( filed within Hygiene. d other tha	<b>Completed</b>	12 0 police officer  17. Father's Name (First, Middle, Last) 18.Mother's Name		· ·	cement
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	To Be	Edwin Francis Wilson   1rma Tt  19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or F  Glenn S. Wilson - son   211 Rolling Knoll Ro		er, City or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 X Donation 5 Other Specify:		20c. Location - City or	
Baltin permit. Departm Imports injury o		21. Signature of Funeral Service Licensee Wade, Director 655 W. Baltimore			21201
Physician /Medical £xaminer		23a. Pat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.  Immediate Cause (Final disease     a. Cervical Neck Fracture	respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and Death
_Adminici		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):  Due to (or as a consequence of):			
be executed sician and urial - transit	Sal	d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be unin 24 hours after death.  the Functal Director: After this certificate has been signed by the attending physicial phetely filled in by the funeral director, page 2 should be detached for use as the burial director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Other (Specify) 9 Unknown	ncy	23d. Date of delivery Month	day Year
, P.O. E	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertension, Diabetes, Hypercholesterolemia, Melanoma, Alzheimer's Dementia		acco use contribute to	
of Vital Records, ag Physician: The law require this certificate has been simeral director, page 2 should b	Completed		24a. Was an autopsy perform	prior to c ed? death?	topsy findings available ompletion of cause of
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?			
f Vid	ဥ	1 Yes 2 No No Inpatient 2 ER/Outpatient 3 DOA Out 4 Nursing	g Home 5 Re	esidence 6 Other	
Division of tal or Attending P as after death.  In Director: After led in by the funeral	Certification:		Subject fell do		eral Bourto Numbras City
Divisior Hospital or Attend 24 hours after death Funeral Director:		Suicide Could not be determined (Specify) Single Family Home	or Town, Stat 10308 Kingsway	te) y Court, Ellicott City	MD
To the Hospital within 24 hours: To the Funeral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date an	nd place, and due to the	e cause(s)
		29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed <i>(Mor</i> September 8, 20	
		Name and address of person who completed cause of death (Item 23a)     Victor Weedn MD JD	re, MD 21223		
	37.73	31. Date fred (Month, Day, Year)   32#Kedistrans Signature # #			

Registrar

1	1_	06583
- 1	1-	00000

1-06583	la in i	Please Type or Print in Black Indelible Ink. Ensure All			ole.	
obert Avrum V		State of Maryland / Department of Health and Me 1- For State Certificate of Death	ental Hyg		2011	28895
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	2.	Reg. I Date of Death	No.	3. Time of Death
ledical Exam		Robert Avrum Weisberg	S	Month Da S <b>eptembe</b> r 1	y Year , 2011	0921 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location		-	4c. County of Deat	h
		Suburban Hospital Bethesda		_	Montgomery	
Funeral Director		Months Days Ho			Earni	rthplace (State or New gn
Director		140-28-2407 1K M 2 F 74 Yrs.	M	lay 24,	1937 C	Jersey
any		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	_	MD Montgomery Garrett Park				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	Intry?
the M	Ö	4414 Cambria Ave; PO Box 428 20896			USA	
with be no	erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic of Married Armed Forces? 14. Never Married 2. X Married Armed Forces?			14. Race - Amer White, etc.	ican Indian, Black,
death or ite	Funera	1 Yes 2 X No		an, etc.)		* 4
s after	ρ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No spec 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Gi		dono Isc	Specify: Wh	
2 hour "natu	ted	Elementary/Secondary (0-12) College (1-4 or 5+)			b. Kind of Business	industry diffe
336 thin 7, than	Completed	12 6 biologist				
5-0( ed wii fygier other	ខ្ញ	17. Father's Name (First, Middle, Last) 18.Mot	ther's Name (Fir	st, Middle, Maid	len Surname)	
21215-0036 Nuld be filed within 7 Mental Hygiene. marked other than	æ		larice 1			
D 2. should and M.	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N  Judith Weisberg - wife 4414 Cambria Av				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho injury or other traumatic event, the Medical Examiner must be notified at once		Judith Weisberg - wife 4414 Cambria Av  20a. Method of Disposition (Name of cemetery,			Oc. Location - City or	
Baltimore, permit. Pages I as Department of Hee Important: If ite	1	1 Burial 2 Cremation 3 Removal from State crematory or other place)			-	
Itimen Partimen Partimen		4 Donation 5 Other Specify: 21. Signature of Fune at Service Lic 11-34 22. Name and Address of Fac	cility State	Anatom	v Board	-11:
Depr.		21. Signature of Fune and Service Lic. 1997. Director 655 W. Balti				21201
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a tailure. List only one cause on each line.	as cardiac or res	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical ≛xaminer	1	Immediate Cause (Final disease a. Anaphylaxis due to probable ins	ect bit	e		Death
Zammei		or condition resulting in death)  Due to (or as a consequence of):				
	P	Sequentially list conditions, if any, leading to immediate bullet (or as a consequence of):				4
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C.				
ted Insit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
executed ian and ial - transit	Gal	x UNPENDED AMENDED 23a,pt.II,27,28a-f,per me	,g921 1	1-21-11	Sm	
ox 68760, nath certificate be ex attending physician for use as the burial	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	<u> </u>
687 ertific ding p	a	past 12 months?	opic pregnancy		Month	Day Year
Sox 6 leath cer attendi for use	/sic	1 Yes 2 No 9 Unknown				
O. B t the de by the	- 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.	23e. Did tobac	co use contribute to	the cause of death?
ires that the signed by the detach	d by	Hypertensive Cardiovascular Disease		1 Yes 2	No 3 Pro	bably 4 🗹 Unknown
ords, w requir	lete			24a. Was an autopsy		utopsy findings available completion of cause of
eco he law ite has	Completed			performed		•
Vital Reco ysician: The law his certificate has director, page 2 s	Be C	25. Was case referred to medical 26.Place of Dea	ath (Check only			
of Vital Records, g Physician: The law require ther this certificate has been si neral director, page 2 should b	일			ome 5 Res	idence 6 Othe	г.
1 Of Jing Ph After t funeral		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at W	I	d. Describe how		insect bite
Sior Attend r death. ector: by the	ertification:	2 X Accident Investigation fd 9-1-11 7:30 am fd				
Divi	ŧ.	3 Suicide 6 Could not be determined (Specify) Suicide of home		or Town, State	9 4414 Camb	ral Route Number, City
Iospit 4 hour 7 uners	O	29a. Certifier		rrett P		ed
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bunneral completely filled in by the funeral director, page 2 should be detached for use as the bunneral completely filled in by the funeral director, page 2 should be detached for use as the bunneral completely filled in by the funeral director, page 2 should be detached for use as the bunneral completely filled in by the funeral director, page 2 should be detached for use as the bunneral completely filled in by the funeral director, page 2 should be detached for use as the bunneral completely filled in by the funeral director.	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death				
T <sub>o</sub>	Me	29b. Signature and title of certifier 29c. License numb	ber	29	d. Date signed (Mo	nth, Day, Year)
		Thinkey My King The Man ) O.C.M.E.	OGME	s	eptember 2, 20	011
	ı	30. Name and address of person who completed cause of death (Item 23a)				
		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore S	Street, Baltii	more, MD 2	1223	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month Year ELAINE JANIS SEPTEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex 8. Date of Birth (Month, Day, You May 24, If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days T928 Director Yrs Kansas 521-32-8841 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1 🗆 Yes 2 No 10f. Zip Code 21702 10g. Citizen of What Country? 10e. Street and Number Funeral 404 Schley Avenue 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ori 1 Never Married 2 Married Completed by Yes Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unit (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H မ Iva Frances Deen Tillman L. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 404 Schley Avenue; Frederick, MD 21702 <u>Jay Wells - husba</u>nd 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State o <u>∓</u> permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Licenses Wade, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. P. 1.1. Enter the disear, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shistory or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition exebrova sculor Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin that the death certificate be executed Cause (Disease or iinjury g physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding p IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Live Gath
Pregnant at time of death
Unknown 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? Month 1 Yes 2 No signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? `≙ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Hypertension page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) director 2 No Other: 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending vork' s after death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 9-6.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fredorica Thomas Thonson

DHMH 17 Rev 7/2009

State Registrar

Division of Vital

Month, Day,

MODA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28897 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07:15 PM MS 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital St. Agnes Baltimore Social Security Number last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. 8. Date of Birth **Funeral** 1 M 2 □ F 9 Months Days Hours Min Carolina Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surtame) ည Williams ant's Name/ lationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Tumber, City or Town, State, Zip Code) 23235 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Fune al Service Licens 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Athero scherotic Cardinyasculas disease or condition resulting in death) 34 W ) Medical Due to (or as a consequence of) Examiner ESRD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence or executed the attending physician and the for use as the burial-transit Emily ween julial that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗆 No Yes 2 No 1 Yes 쏊 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗗 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending injury (Month, Day, Year) Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation within 24 hours after deatl To the Funeral Director. 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PG1Y2 P25483 09/06/20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900s caton Ave, Battimer MD21229 Visioana than Si Agnes Hospitch Priyor 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

N. III.

Williams.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept. 6 Day 201 1 a Alphonzo Washington 00:33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1 🗔 M 2 🗆 F Days Hours 579-42-6027 1 257 1935 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington DC 1 🔀 Yes 2 🗆 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a USA 20019 4609 East Capitol St. 12. Was Decedent Evenin U.S Armed Forces? UKN • Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married 1 ★ Yes 2 No If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 'natural", Completed 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Govt. Printing Ofc than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government n and Mental Hygien 7 is marked other th Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) I and 2 should be fi FHealth and Mental ပ Janette Easton Berdale Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9511 Acova Park St. Capitol Heights 43 MD 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Stephen Washington/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/13,2011 Brentwood, MD Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's 3831 Georgia Ave. NW Funeral Home Inc. washington DC 20011 cc0278 23a. Part 1. Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events -trar attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death s after death. Il Director: After th 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ATTENDING PHYSIUM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD #205, GLENN DALE MOZO769 MOMOH MD 12150 ANNAPOLIS 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:50P<sub>M</sub> Year 201 Eugene Wax Marlowe SEPTEMBEŔ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month 1 X M 2 D F 212-08-0949 Yrs. Director 39 MD Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene. Fant: If Item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examiner must be I Funeral U.S.A. 21229 526 Lucia Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Cleaning Business Self Employed пa Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rosemary Barber 2 Milton M. Wax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derrel Jones-Son 5653 Purdue Ave Apt F, Baltimore, Μđ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 9/12/2011 Baltimore, Md Cedar Hill 21 Sign ture of Funeral Service Lice 22. Name and Address of Facility
March F. H. West
4300 Wabash Ave, smald Baltimore, 21215 Μđ 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SEPTIC SHOCK Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner GRAM NEGATIVE BACTEREMIA Sequentially list conditions, if any, leading to inspectate cause. Enter Underlying Due to for as a consequence of Exam ALCOHOLIC LIVER DISEASE burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): a tending physician Physician/Medical death certificate be 68760 the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the g 🗌 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Records, Completed RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? Yes 2 N 2 🗌 No 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 XNatural 5 Pending injury Investigation

Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b **Division of Vital** Certificate: 2 Accident
3 Suicide
4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed D24034 of death (Item 23a) (Type, Print) 30. Name and address of person who complet

State Registrar

TIMOTHY LOW, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day,

Month, Day, Year)

11-06011 Curtis Wiley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Curtis Wiley	Registrar	tate of Maryla	nd / Depai Cert	rtment of F tificate of L	lealth a	nd Ment	al Hygiene	Reg. No.	2011	28900
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Curtis Wiley	lle,Last)					2. Date of Month		Year	3. Time of Death
The state of the s	4a. Facility Name (if not institution 5346 Maple Avenue	on, give street and num	nber)		City, Town, o	or Location of	Death		c. County of De	
Funeral Director	5. Social Security Number 240–82–2913	6. Sex	7. Age (In yrs. las	-	If Under 1 Ye Months Da		24Hrs. B. Date	of Birth (MM.	/DD/YYYY) 9. Foi	Birthplace (State or reign NOTTh Country) Carolina
laryland 8a-f show any at once.	Usual Residence of Decedent  10a. State 10b. County  MD			own or Location						10d. Inside City Limits
rith the Maryland 23a or 28a-f sh notified at one al Director	10e. Street and Number 5346 Maple A				Of. Zip Code 2121			US	zen of What C	ountry?
or item	1 Never Married 2 M	Armed For 1 X Yes  orced If Yes, Give Year	2 No	If Yes,	specify Cuba	n, Mexican, F  specify:	? ( Specify Yes o Puerto Rican, etc.	tc.) White, etc		ack
1215-0036 be filed within 72 hours after the other than "natural"; refed other than "natural"; rent, the Medical Examiner Be Completed by	Elementary/Secondary (0-12)	College (1-4			of working life	eciali	se retired)			f Labor
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than rite twent, the Medical TO Be Comple	Walter Linwood Wiley Sr.				dress (Stro	Marg	Name (First, Midd aret Lou er or Rural Route	ise L	ove	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Fleatht and Mental Hygicen. Important: If item 27 is marked other thingry or other transmatic event, the Med To Be Comp	April Williams 20a. Method of Disposition 1 Burial 2 Cremation	s - niece	20b. Pla	114 N	ichols	Ave;	Roxboro,	Nort	h Caro	ate, Zip Code)  Lina 27573 or Town, State
	4 Donation 5 X Other Sp 21. Signature of Funeral Service Ronal d S	ecity in state				s of Facility	State An	atomy	Board	
/Medical Examiner	23a. Part I. Enter the disease, or tailure. List only one cause of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	complications that cause neach line.  a. Narcotics (Monopole to the content of the cause)  Due to (or as a content of the cause)  Due to (or as a content of the cause)	orphine) Into	o not enter the m	ode of dying	altimon	re St; B	altimo	ore, MD	Approximate Interval Between Onset and Death
50, e be executed ysician and burial - transit edical Exa	events resulting in death) Last UNPENDED	Due to (or as a co	nsequence of):							
Box 6876: death certificat the attending photo of for use as the hysician/M	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	1 Live birth 4 Pregnant own 9 Unknown	at time of	2 Fetal de 5 Other	(Specify)	Ectopic pre	egnancy		Date of delive Month	pry Day Year
cords, P.O.  I law requires that the that been signed by the that the control of the control that the control of the control that the control of the control	art II. Other significant conditio	ns contributing to de	eath but not resul	ting in the under	lying cause g	iven in Part I.	1 ,	res 2	No 3 Pro	the cause of death?
Division of Vital Records, rat or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be riffication: To Be Completed	5. Was case referred to medical	T			26 Place	of Death (Che	pe 1 ✔ Ye	topsy rformed?		utopsy findings available completion of cause of 'es 2 No
of Viting Physicing Physicion After this connertd direction To B	examiner?  1 V Yes 2 No  7. Manner of Death			/Outpatient 3	DOA	Other Nu	rsing Home 5		ce 6 🗸 Othe	er: Scene
Division of viral or Attending Phurs after death. Tal Director: Aftert liled in by the funeral ertification: T	Natural 5 Pendir Investi	gation Aug 10, 20	y,Year) FC	DUND: 122 hrs	1 Y	y at Work? es 2 🗸 No	28d. Describ Unknown			
Divis Hospital or A 24 hours after Funeral Dire lely filled in b	Homicide determ	ined (Specify) F	ound in Resi	dence			Found: 534	, State) 5 Maple A	venue, Baltin	
within To the comple	ne) 2 ✓ Medical Exami Db. Signature and title of certifier	sician: To the best of ner: On the basis of ex and manner state	kamination and/o	r investigation, in	my opinion,	death occurre	and due to the ca	te and place	e, and due to the	ne cause(s)
30	O. Name and address of person w	no completed cause of	death (Item 22a		O.C.N				st 11, 2011	
		tant Medical Exa			e Street, E	Baltimore,	MD 21223			

Registrar

OHMH 17 Rev 1/2001

State

31. Date filed (Month, Bay, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	ate of Maryla		artment of H			ene	28902
			Decedent's Name (First, Middle, Last)	-				2. Date of Death	1	3 Time of Death
	Physicia Medic		EILEEN WENI	NERLYN W	EAVER			SEPTEMB1	ER 8, 2011	. 2:15 P <sup>M</sup> _
	Examir	er	4a. Facility Name (if not institution, give street ar	<i>'</i>		4b. City, Town, or	Location of Death		4c. County of Dea	
			Ellicott City Health				tt City		Howard	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	V F	s. last birthday)  6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 17	Year) 9. Bi	rthplace (State or Foreign ountry)
			Usual Residence of Decedent	9	6 Yrs.			Feb. 17	, 1915 Min	inesota
	land show	호	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-i otifie	Director	MD Howard		Fulton					1 ☐ Yes 2X No
	th the	a D	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	ountry?
	ms 23 must	Funeral	12502 Hall Shop Ro		T		0759		USA	
<b>'</b> O	or ite	by Ft	Arm	s Decedent Ever in ned Forces? Yes 2 🗓 No	U.S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
036	s afte ral", ( Exan		if Ye	es, Give or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify: Wh	nite
2-0	hour 'natu	Completed	15. Decedent's Education (Specify only highest grade comp	nleted)		lent's Usual Occupa			16b. Kind of Business	s Industry
2	nin 72 ne. <b>.han</b> '	E		lege (1-4 or 5+)	life. Do	kind of work done do O NOT use retired)	uring most of work	aing	American	Kennel
2	d with	BeC	12th	Ø		Judge			Associat	ion
Baltimore, Maryland 21215-0036	oe file antal H ced o c eve	10	17. Father's Name (First, Middle, Last)  Arthur G. Wennerlyr	-				ne (First, Middle, Mi	, and the second	
<u>7</u>	nd Me marl		19a. Informant's Name/Relationship (Type, Print		10h Mailin	a Address (Street a		Clarice S	Sity or Town, State, Z	in Cadal
Š	d 2 sk alth a 1 27 is ar trau		Robert A. Hughes/ Pe	,	1.			, Fulton		
ore,	of He of He item		20a. Method of Disposition	20b	o. Place of Dispo				20c. Location - City o	
<u>Ĕ</u>	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "matural", or items 23a or 28a-f show amportant in i		1 ☐ Burial 2 💢 Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)			ndel Crem		0/2011	Odenton,	MD
Salt	ermit. eparti nport ny inj		21. Signature of Funeral Service Licensee	-61	22	. Name and Address	s of Facility Do	naldson I	Funeral Ho	ome, P.A.
	0 □ = a o	_	Janie CL & Y	M01		313 Talbo				707
			23a. Part 1. Efter the disease, or complications shock, or heart failure. List only one cause							Approximate Interval Between
****	h sician/ Medical	0 0	Immediate Cause (Final disease or condition resulting in death)	Alker	oscler	olic Car	diova	Colar,	Direade	Onset and Death
	Examiner			ue to (or as a conse	equence of):	ecen			Discase	!
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a conse	equence of):					
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.							
	e exec cian al urial-t	al E	resulting in death) Last D	ue to (or as a conse	equence of):					
200	ate b	edical	d							
687	sertific Iding Ise as	W/C	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	es, outcome of preg	gnancy				00 d Data of d	
Вох	eath c atter	iciai	in the neet 12 mounts?	Live Birth 2 F Pregnant at time of	etal death 3 _ of death 5 _	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	Day Year
O. E	the di by the achec	Physician/Me	9 Unknown 9	Unknown						
<u>Р</u> .	s that gned	by F	Part II. Other significant conditions contributing	g to death but not r	resulting in the u	nderlying cause give	en in Part I.		_	o the cause of death?
rds.	equire	ted						1 🗌 Ye	s 2 No 3 I	Probably 4 Unknown
Ö Ö	law re nas be e 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ž	: The icate , pag							perform 1 Yes 2	death?	es 2 No
<u>ita</u>	siciar certif irecto	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:			Othor	ce of Death (Chec			
<u> </u>	g Physer this eral di	e: <u>1</u> 0	27. Manner of Death 28a.	1 Inpatient 2 Date of injury	28b. Time of	28c, Injury	Nursing Ho	ome 5 Resider  28d. Describe hov	nce 6 Cther (Spervinium occurred	cify)
uo :	anding sath. Ir: Afte	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 □ \	res 2 □ No		,,	
Division of Vital Records,	r Atter de ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
בֿ ב	oital o								·	
:	Hos 24 hc Fund leted 1	edical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the control of the contr	he basis of examinat	tion and/or investi	gation, in my opinior	n, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 ☐ Certifying Nurse Practic 29b. Signature and title of certifier	ziter: TO the best of	my knowledge, d	29c. License	number	e, and due to the d	d. Date signed (Moni	th, Day, Year)
	1/65		> EGlanus			D3	0641		Ochober	9 2011.
	NIZ		29b. Signature and title of certifier  & Claum  30. Name and address of person who completed  Ramerh Sabapathi  31. Date filed (Month), Day, Year)  SEP 1 2 2011	cause of death (Ite	em 23a) (Type, Pr	rint)	Oct 12	ad Com		10. 121121
	- 01-1		Kamesh Jabapahi 31. Date filed (Morlin, Day, Year)	201-109	13aac	KIVEY N	KUK KO	49 215	ta Num	ing elect
	Stat Registra	_	SEP 1 2 2011	and sold	p. 40	Ros				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bruke Wone Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death W. Bilt Mile 2000 SalTIMOTE 8. Date of Birth 9. Birthplace (State or Foreign Country)unk If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 🕅 M 2 □ F Months Days Hours Min. an Month, Day, yeary 62 **Director** 214-50-3950 Usual Residence of Decedent fshow unk 10a. State 10b. County unk with the Maryland notified at 10c. City, Town or Location 10d, Inside City Limits unk \_ Director 28a-f 1 Yes 2 No MD10e. Street and Number unk unk 10f. Zip Code ō 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other trainmatic 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 W. Baltimore St; Baltimore, MD 21223 Bon Secour Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) in state cemetery, crematory or other place, Sign ture noral Service 22. Name and Address of Facility State Anatomy Board irector\_ 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, If any, leading to in mediat cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 \$\mathbb{Y}\$ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed Yes 2 this certificate 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ Inpatient 2 🗆 ER/Outpatient 3 DOA After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Nar

e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 05 A. woods eanne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Charlestown Retirement Center Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Hours Sept 5, 1918 Maryland Director 216-10-9519 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🚻 No Catonsville MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Lane; PV315 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) substitute teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Stankiewicz Mary Pfaifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Schaeffer - daughter 1310 Tarcove Rd; Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 21. Signatur of Emeral Service L 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) corona a. acute Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Severe anemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: ျ 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation after death Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [] 3 [] only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Denein

31. Date filed (Month, Day, Year)

2 2011

1

711

32. Registrar's Signature

Maiden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Medical INEZ WAITES September 6 2011 11:45 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1100 WALNUT AVENUE BALTIMORE BALTIMORE CO Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 🗆 M 2 🔯 F Months Days Min. Hours Director Yrs. 213-32-4762 78 3-03-1933 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD 1X☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1100 WALNUT AVE. 21229 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ٥ 1 X Never Married 2 - Married and 2 should be filed within 72 hours after Health and Mental Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify: Completed BLACK Maryland 21215-00 event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INDUSTRIAL SEAMSTRESS CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARSHALL S. JONES CARRIE I. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. COLLINS WAITES/HUSBAND 1100 WALNUT AVE. BALTIMORE, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL PARK 9/12/2011 BALTIMORE, MD WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final small cell Physician/ (dance disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier University Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy
performed?

Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature and 29c. License number 30185 2011 who completed cause of death (Item 23a) (Type, Print) com replied

Registrar DHMH 17 Rev 7/2009

State

0.

31. Date filed (Month, Day, Year) SEP 1 2

Frederic

Radd

405

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28906 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6<sup>Day</sup> Physician/ Month Matthew Williams 2011 1:45 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Gilchrist 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours **Director** 241-30-4183 1 V M 2 F 87 3/27/1924 N.C. 28a-f show 10a, State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD N/A Baltimore 1 X Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be 21233 1227 Knights Woods Rd USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ò 1 X Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 ☐ Yes 2 XNo Specify: "natural", 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Car Wash Company Car Washer 8th N/A other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Connie Stokes Leroy Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1227 Knights Woods Rd. Balto., MD 21233 Diane Williams-Niece 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Donation 5 Other (Specify) 9/12/2011 OwingsMills, MD 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility March F/H 1101 E. North 1. Mellin 21202 Ave. Baltimore, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 06 4005 Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of Exami The law requires that the death certificate be executed Due to (or as a consequence of): burial-t attending physician I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of Was an has page 2 autopsy death? certificate 2  $\square$  No 1 🗌 Yes Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2H No Other: 1 Yes မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this a completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and titl 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mon marz6s 31. Date filed (Month, Many Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 2011 01:00PM 07 av otember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours Min. Director Country) 226-54-4418 10 16 Usual Residence of Decedent or 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Yardley Court 21244 U.S.A. within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natul any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade & Nutrition Svcs Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Gillis Annie Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Young-Husband Yardley Court, Baltimore, Md 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) On-Site 9/17/2011 Baltimore, Signature Puneral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ a Attracteroscie COYDNAMU Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

124 hours after death.

154 Fromeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Certificate: To 1 🗌 Yes Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HO07250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible in fine All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28908 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Irma Teresa Alfonso Medical 2011 August 1:28pm 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Thomas More Hyattsville Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K F Sept. 28, 1926 Director 84 Cuba Cuntry) 577-68-3059 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified DC N/A Washington 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 413 Rittenhouse Street, N.W. United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc Ş Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 X Yes 2 No Specify: Cuban "natural", 3 
Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Secretary **GEICO** other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o and 2 should be Catalino Alfonso Maria Luisa Iribe-Andudi of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lourdes Ruiz/Niece 19800 Northwest 44th Ave., Miami Gardens, FL 33055 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Silver Spring, MD Gate of Heaven 08/24/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) RAG Medical Due to (or as a consequence of): Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No for Pregnant at time of death Day Year the 9 Unknown Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Drabetes Mellitre 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autonsy performed? death? certificate | 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: မ Other: this 1 Inpatient 2 ER/Outpatient 3 DOA W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide Investigation 1 🗌 Yes 2 🗆 No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

AUG 24 2011

30\_Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Queenshing Rd Hartsville MD 20781

Registrar DHMH 17 Rev 7/2009

State

Bindu C.

31. Date filed (Month, Day, Year) AUG 2 4 2011

P.O. Box 68760

Records,

Division of Vital

1160 Varnum St..

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph,

M.D.,

D0060634

#021, Washington, DC 20017

29d. Date signed (Month, Day, Year)

August 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28910 Reg. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Santiago Allende Month Day 2011 Auq. 21 3:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Larkin Chase Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Hours Mir 1 XM 2 F Months 88 Yrs 05/23/1923 Puerto Rico Director 579-38-8644 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD 1X Yes 2 No Prince George's Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 15005 Health Center Drive 20716 USA death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Korean
Year or Dates. Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 

Yes 2 □ No Specify: Puerto Rican White "natural" Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant **IRS** other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allende Nicolas Lucia Vivas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health ai Important: If item 27 is any injury verses Vida McAuliffe/Niece 14940 London Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 08/24/2011 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of John ral Service Licenson Beall Funeral Home 22. Name and Address of Facility 20715 6512 NW Crain Hwy., Bowie, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Alzheimers Dementia disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of): requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown b ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ه ا 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🔀 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify eral Director: After this if 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1X Natural 5 Pending death. 2 Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined after City or Town, State) Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопрете Medical Examiner: Or Certifying Nurse Pra (Check tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of a 29c. License number 29d. Date signed (Month, Day, Year) D43351 8/22/2011 531

DHMH 17 Rev 7/2009

State

Registrar

Dr. Ikechi Okwara, 12200 Annapolis Rd., #316, Glenn Dale, MD

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 4 2011

32

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n 1 - For State Registrar Amend #14. FH, TCHD, pha 8/22/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mary Louise Armentrout 020 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sa Wicomico Salisbury Rehabilitation Nursing (tr is bour 8. Date of Birth Birthplace (State or Foreign Country) MD Social Security Number If Under 1 Year If Under 7. Age (In yrs. last birthday) **Funeral** Days 1-26-1921 1 □ M 2 😿 F Months 214-30-7928 90 Yrs Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 😾 No MD Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or items 23a or important if Item 27 is marked other than "natural", or items 23a or in injury or other traumatic event, the Medical Examiner must be a one. Funeral 5565 Ben Davis Rd 21850 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Black, White, etc. White Arment Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) O College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Clothing Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Giles H. Marshall Mary E. Jump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margorie A. Morris (Daughter) 5565 Ben Davis Rd Pittsville, MD 21850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Woodlawn Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 8-25-2011 Easton, MD Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home P.A. MERCERDO Harrison St Easton MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy performed? death? 2 🗌 No 2 = N Yes 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours after To the Funeral Direc City or Town, State) Medical 🚅 🌜 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner. To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bury Kobins M.D. Jilliam H 31. Date filed (Month, Day, State **AUG 22** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryl				nd Mental H	ygiene			00010
			State Registrar		Cei	rtificate of <i>E</i>	Death		Reg. N	201	1	28912
	Physicia	ın/	1. Decedent's Name (First, Middle, Las Gary Edward	,	nsteckei	•		2. Date of Month	Da		ear	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of C	Augus Death		. 2011 County of I	Death	5:20 P M
	Examin		1101 Higgins Pl	ace #203			ville		Montgomery			
П	Funeral		5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year Months Days	If Under 24		Birth Day, Year)			ace (State or Foreign
	Director		316-62-3528 Usual Residence of Decedent	X-M-2-1 3/	Yrs.			July 1	7. 1	954	MI	
	and show	or	10a. State 10b. County	10c.	10c. City, Town or Location						10	d. Inside City Limits
	Maryla 28a-f	rect	MD Montgo	merv	Rockvill	P						1 XYes 2 ☐ No
	a or 2	Funeral Director	10e. Street and Number	····		10f. Zip Code			10g. C	tizen of Wha	t Countr	ry?
	th with ms 23 must	iner	1101 Higgins PLac			208				U.S.		
10	or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin: n, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - A Black, V	America Vhite, et	
036	s afte	q pe	3 ☐ Widowed 4基 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2🔀 No	Specify:			Specify:	Whit	re
21215-0036	natu dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation		dent's Usual Occupa		working	16b. I	Kind of Busin		
2	hin 72 ne. than '	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)	rumig most or	WOIKING				
0 0	ed wit Hygie other	a)	17. Father's Name (First, Middle, Last)	5 <del>±</del>	l_Att	orney	18 Mother's	Name (First, Midd		-	ent	of Labor
au	be fill ental rked c	힏	Harlan A. Bernste	cker				a L. Leit		Surrame)		
ary	hould and M is mai		19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a				r Town, State	e, Zip Co	ode) 46268
Σ	ealth an 27 in 27 ier tra		Martha L. Bernste	cker/Mother	2502	Arbor Way	y Lane	Apt. #31	.6 In	dianap	olis	s, IN
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🔀	Removal from State	<ul> <li>b. Place of Dispo cemetery, great</li> </ul>	osition (Name of natoryor other plac Cemetery	:e)	Date		ocation - Cit		
E H	it. Pag rtmen rtant; rjury		4 Donation 5 Other (Specification)					3/22/2011				lal Chapels
Ba	perm Depa Impo any i		21. Signature of Funeral Service Licens  MCG reenno			Name and Address 70 Rockvi						
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the d ne cause on each line.	leath. Do not ente	er the mode of dying	g, such as car	diac or respiratory	arrest,			Approximate Interval Between
F	nysician/		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line. a. <u>Cardiac</u>	Arrythmi		g, such as can	diac or respiratory	arrest,			
	Prysician/ Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line. a. Cardiac A  Due to (or as a cons	Arrythmi sequence of):	a	g, such as car	diac or respiratory	arrest,		Mi	Interval Between Onset and Death
	Medical Examiner	ner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any hearing to immediate	ne cause on each line. a. <u>Cardiac</u>	Arrythmi equence of: ive Slee	a	g, such as car	rdiac or respiratory	arrest,		Mi	Interval Between Onset and Death Lnutes
-	Medical Examiner	aminer	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or imjury)	a. Cardiac  Due to (or as a cons  Obstruct	Arrythmi equence of: ive Slee	a	g, such as car	diac or respiratory	arrest,		Mi	Interval Between Onset and Death Lnutes
-	Medical Examiner	al Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any healing to immediate cause. Enter Underlying	a. Cardiac  Due to (or as a cons  Obstruct	Arrythmi sequence of: ive Slee	a	g, such as car	diac or respiratory	arrest,		Mi	Interval Between Onset and Death Lnutes
-	Medical Examiner	lical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events	a. Cardiac Due to (or as a cons	Arrythmi sequence of: ive Slee	a	g, such as car	diac or respiratory	arrest,		Mi	Interval Between Onset and Death Lnutes
-	Medical Examiner	lical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Cardiac Due to (or as a cons	Arrythmi sequence of): ive Slee sequence of):	a	g, such as car	diac or respiratory	arrest,	23d Date o	1	Interval Between Onset and Death Linutes Year
-	Medical Examiner	lical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any hearing to the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Cardiac Due to (or as a consol.  Due to (or as a consol.  Due to (or as a consol.  Due to (or as a consol.  Due to (or as a consol.  Live Birth 2   1   2   4   2   4   4   4   4   4   4   4	Arrythmi equence of): ive Slee sequence of): sequence of): gnancy Fetal death 3	a		diac or respiratory	arrest,	23d. Date o Month	Mills of deliver	Interval Between Onset and Death Linutes Year
-	Medical Examiner	lical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a. Cardiac Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 3 of death 5 of	Ectopic pregnanc Other (specify)	.y	diac or respiratory	arrest,		Mills of deliver	riceval Between Operate and Death Linutes Year
-	Medical Examiner	by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading time death cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — No	a. Cardiac Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 3 of death 5 of	Ectopic pregnanc Other (specify)	.y	23e. Did	d tobacco	Month use contribut	Mil 1	y Oay Year  y Cause of death?
-	Medical Examiner	by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a. Cardiac Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 3 of death 5 of	Ectopic pregnanc Other (specify)	.y	23e. Did 1 [	d tobacco ☐ Yes 2	Month use contribut	Mills of deliver.	y Year  cause of death?  abily 4 Unknown
-	Medical Examiner	by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a. Cardiac Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 3 of death 5 of	Ectopic pregnanc Other (specify)	.y	23e. Dic 1 [ 24a. Wau	i tobacco	Month use contribut  No 3 [  24b. Were prior	Mil 1 1 Probate autops r to com	y Oay Year  y Cause of death?
-	Medical Examiner	Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final Idsease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions conditions conditions.	a. Cardiac Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)  Due to (or as a consolor)	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 3 of death 5	Ectopic pregnanc Other (specify)	ry ven in Part I.	23e. Did 1 [ 24a. Wi au pe 1 □ Ye	i tobacco ☐ Yes 2	Month use contribut  24b. Wern prior deat	Mil 1 1 Probate autops r to com	y Year  y Year  cause of death?  ably 4 Unknown  sy findings available pletion of cause of
-	Medical Examiner	Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final Idsease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or impluy that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions conditions conditions can be seen that the conditions condit	a. Cardiac Due to (or as a cons Due to (or as a cons C. Due to (or as a cons d.  Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 3 [ resulting in the u	Ectopic pregnanc Other (specify)	even in Part I.	23e. Did 1 [ 24a. Wi au pe 1 □ Ye Check only one)	i tobacco Yes 2 as an topsy rformed? s 2 \( \sqrt{N} \)	Month use contribut 24b. Wer prior deat o 1	f deliver	y Year  y Year  cause of death?  ably 4 Unknown  sy findings available pletion of cause of	
-	Medical Examiner	To Be Completed by Physician/Medical	shock, or heart failure. List only of Immediate Cause (Final Idsease or condition resulting in death)  Sequentially list conditions, if any leading the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Cardiac Due to (or as a cons  C. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  C. Due to (or as a cons  d. Due to (or as a cons  d. Pregnant at time 9 Unknown  Due to death but not	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 5   resulting in the u  ER/Outpatier 28b. Time of	Ectopic pregnanc Other (specify) Inderlying cause givent 3 DOA  28c. Injury	even in Part I.  ace of Death (in the series of the series	23e. Did 1 [ 24a. Wi au pe 1 □ Ye	tobacco Yes 2 as an topsy rformed? s 2 \( \sqrt{N} \)	Month use contribut  24b. Wen prior deat or 1   Other (S	f deliver	y Year  y Year  cause of death?  ably 4 Unknown  sy findings available pletion of cause of
-	Medical Examiner	To Be Completed by Physician/Medical	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any Lating Limmediate cause. Enter Underlying Cause (Disease or implury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Cardiac Due to (or as a cons Obstruct Due to (or as a cons C. Due to (or as a cons d. Due to (or as a cons d. Pregnant at time 9 Unknown Ontributing to death but not  Hospital: 1 Inpatient 2 28a. Date of injury (Month, Day, Year,	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death 5 [ of death 5 [ resulting in the unity of the content of t	Ectopic pregnanc Other (specify)  Inderlying cause give  26. Plat 3 DOA Other  28c. Injury work 1	even in Part I.  ace of Death (in the series of the series	23e. Did  1 [  24a. Wi appe 1 □ Ye  Check only one)  ng Home 5 ☑ Re  28d. Describ	i tobacco Yes 2 as an topsy rformed? s 2 N	Month use contribut 24b. Wer prior deat 1 □ Cher (S	f delivery te to the Probate autops r to community? Yes 2	y Year  y Year  y Year  y Year  cause of death?  ably 4 Unknown  sy findings available pletion of cause of
-	Medical Examiner	To Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final Idisease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or implury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Cardiac Due to (or as a cons Obstruct Due to (or as a cons C. Due to (or as a cons d. Due to (or as	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death 5 [  resulting in the u  BER/Outpatier Calculation of injury  thome, farm, streen	Ectopic pregnanc Other (specify)  Inderlying cause give  26. Plat 3 DOA Other  28c. Injury work 1	even in Part I.  ace of Death (the Prime of A Death (the Prime of	23e. Did 1 [ 24a. Wing au per  1   Ye   Check only one) 1   Received the per  28d. Describ 28f. Location	i tobacco Yes 2 as an topsy rformed? s 2 N	Month use contribut 24b. Wen prior deat 0 1 0  Other (S	f delivery te to the Probate autops r to community? Yes 2	y Year  y Year  cause of death?  ably 4 Unknown  sy findings available pletion of cause of
-	Medical Examiner	Certificate: To Be Completed by Physician/Medical	shock, or heart failure. List only of Immediate Cause (Final Idisease or condition resulting in death)  Sequentially list conditions, if any cause. Enter Underlying Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Cardiac Due to (or as a cons Obstruct Due to (or as a cons C. Due to (or as a cons d. Due to (or as	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death 5  resulting in the u  ER/Outpatier 28b. Time of injury  t home, farm, streetify)	Ectopic pregnanc Other (specify)  Inderlying cause give  26. Plant 3 DOA  28c. Injury Work M 28c. Injury Work H 1 DOA	eren in Part I.  acce of Death (territoria)  acce of Death (territoria)  acce of Death (territoria)  acce of Death (territoria)	23e. Did 24a. Wau pe 1	d tobacco  Yes 2 as an topsy rformed? s 2 N sidence (e how injure)	Month use contribut 24b. Wen prior deat of 1 Other (S y occurred	f deliver	y Year  Year
-	Medical Examiner	To Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or implury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions	Cardiac Due to (or as a cons  Due to (or as	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death of death of death of death of death of death of death of death of injury  Legion 1	Ectopic pregnanc Other (specify)  26. Pla  27. Pla  28. Injury Work M 28. Injury Work 1  29. State of the time, tigation, in my opinio	even in Part I.  ace of Death (in according to the place of the place	23e. Did  24a. W. au p ye Check only one)  ng Home 5 😿 Re 28d. Describ  28f. Location City or 7	as an topsy rformed? s 2 N N sidence (a how injure town, State cause(s) a e and place	Month use contribut use contribut 24b. Wer prior deat 0 1   Other (S y occurred  od Number or )  and manner as a, and due to	Mills In the community of the total and the community of	y Year  Year
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or possible to the funeral director.	Certificate: To Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or implury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions	a. Cardiac Due to (or as a cons Obstruct Due to (or as a cons C. Due to (or as a cons d. Due to (or as	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death of death of death of death of death of death of death of death of injury  Legion 1	Ectopic pregnanc Other (specify)  26. Pla  27. Pla  28. Injury Work M 28. Injury Work 1  29. State of the time, tigation, in my opinio	even in Part I.  ace of Death (in the property of the property	23e. Did  24a. W. au p ye Check only one)  ng Home 5 😿 Re 28d. Describ  28f. Location City or 7	as an topsy formed? s 2 12 N sidence (a lown, State cause(s) a a and place the cause(the cause(s) at a lown, state cause(s	Month use contribut use contribut 24b. Wer prior deat 0 1   Other (S y occurred  od Number or )  and manner as a, and due to	f delivery  te to the Proba e autopser to com th? Yes 2  Specify)  r Rural Fi s stated, the causer as state	y Year  Year
-	Medical Examiner	Certificate: To Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final Idsease or condition resulting in death)  Sequentially list conditions, if any least or conditions are cause. Enter Underlying Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Cardiac Due to (or as a cons  Due to (or as	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death 5 [  resulting in the understand injury  thome, farm, structify)  owledge, death of attion and/or investif my knowledge, of the control of t	Ectopic pregnanc Other (specify)  Inderlying cause give  26. Plant 3 DOA  The 28c. Injury work 1 Deet, factory, office Deccured at the time, tigation, in my opinio death occurred at the lime, tigation, in my opinio death occurred at the 29c. License	even in Part I.  ace of Death (in the property of the property	23e. Did  24a. W. au p ye Check only one)  ng Home 5 😿 Re 28d. Describ  28f. Location City or 7	i tobacco  Yes 2 as an topsy rformed? s 2 N sidence (a how injure) (Street ar own, State cause(s) a a and place the cause(	Month use contribut use contribut 24b. Wer prior deal o 1  Other (S y occurred  and Mumber or ) and manner as a, and due to s) and manner	Mills 1  If deliver, the to the eautops of the company of the causer as stated, the causer as stated onth, Date 18,	y Year  Year
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or possible to the funeral director.	Certificate: To Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or implury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions conditions are carminer? 1   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 3   No   Yes 4   Yes 5   Yes 4   Yes 5   Yes 5   Yes 5   Yes 5   Yes 5   Yes 6   Yes 6   Yes 7   Y	a. Cardiac Due to (or as a cons Obstruct Due to (or as a cons C. Due to (or as a cons d. Due to (or as	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death of death of death of death of death of death of death of death of death of death of injury  Lender of the death of the death of death	Ectopic pregnanc Other (specify)  26. Plant 3 DOA Other 28c. Injury work 1 Deet, factory, office occurred at the time, tigation, in my opinio death occurred at the	even in Part I.  ace of Death (interpretation of the processing of the processing death occur in time, date and place in time, date and processing of the pr	23e. Did  24a. W. au p y Check only one)  ng Home 5 🔀 Re 28d. Describ  28f. Location City or 7  ce, and due to the red at the time, dat d place, and due to	as an topsy formed? s 2 N N sidence (e how injure own, State cause(s) a e and place the cause(formed) and the cause(formed) A	Month use contribut 24b. Wen prior deat of 1 Other (S y occurred and Number of and manner as a, and due to a) and manner atte signed (M	Mills of delivery te to the Probate autops r to company the Probate stated the causer as stated the causer as stated touth, Delivery 18, 20	y Year  Year
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or possible to the funeral director.	Medical Certificate: To Be Completed by Physician/Medical	shock, or heart failure. List only or Immediate Cause (Final Idsease or condition resulting in death)  Sequentially list conditions, if any least or conditions are cause. Enter Underlying Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Cardiac Due to (or as a cons Obstruct Due to (or as a cons  Due to	Arrythmi sequence of):  ive Slee sequence of):  gnancy Fetal death of death	Ectopic pregnanc Other (specify)  Inderlying cause giv  26. Plant 3 DOA  28c. Injury Work M 28c. Injury Vork Ligation, in my opinion Jeath occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigation occurred at the time, tigati	even in Part I.  ace of Death (interpretation of the processing of the processing death occur in time, date and place in time, date and processing of the pr	23e. Did  24a. W. au p y Check only one)  ng Home 5 🔀 Re 28d. Describ  28f. Location City or 7  ce, and due to the red at the time, dat d place, and due to	as an topsy formed? s 2 N N sidence (e how injure own, State cause(s) a e and place the cause(formed) and the cause(formed) A	Month use contribut 24b. Wen prior deat of 1 Other (S y occurred and Number of and manner as a, and due to a) and manner atte signed (M	Mills of delivery te to the Probate autops r to company the Probate stated the causer as stated the causer as stated touth, Delivery 18, 20	y Year  Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1:57 A<sup>M</sup> August Sara Nannette Beren Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Suburban Hospital Bethesda Date of bill. (Month, Day, Year 29, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday 8. Date of Birth 1 M 2 1 92 Months Days Hours Year) Director 1919 Michigan 379-12-3758 March 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Rockville 1 X Yes 2 □ No Montgomery 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6121 Montrose Road, 509 West 20852 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 0 ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify. "natural" 3 → Widowed 4 □ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Bridal Shop Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F item 27 is marked o ည Joseph Frumkin Bessie Benison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel J. Beren/Son 15732 Falls Road, Butler, Maryland 21023 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once, 1 → Burial 2 □ Cremation 3 → Removal from State 4 □ Donation 5 □ Other (Specify) 08/19/2011 | Flint, Michigan Machpelah Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityEdward Sagel Funeral Direction Migreenhut mo1597. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Pnysician/ SHOCK SEPTIC Medical Due to (or as a consequence of) Examiner PINEDMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): FATILUME CONCESTIVE FIEANI the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last buria attending physician Physician/Medical AULTIC STENUSIS Division of Vital Records, P.O. Box 68760 X the l IF FEMALE: Z Se 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death ed by the detached 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 30 performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 9 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.
To the Funeral Director. After th completed filled in by the funeral PD, SQVQ OS 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) S itle of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Ser

MTCHAFL

31. Date filed

AUG 2 4 2011

8600

2. Registrar's Signature

OLD GEORGETOUN GETHES DA

AXELSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

70814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Danny Lee BURDETTE, Sr. Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Meritus Medical Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours Year 1943 Oct. IZ, Maryland 215-38-6386 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Washington Maryland Sharpsburg 1 Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. Funeral 21782 6718 Dam #4 Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1962 and Mental Hygiene. Is marked other than "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after white 1968 1 ☐ Yes 2X No Specify: Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) painting contractor painter 12 Be 18. Mother's Name (First, Middle, Maiden Surname)

Dellathia Boyce 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ೭ Rodney Burdette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 21782 6718 Dam #4 Road, Sharpsburg, Maryland Teresa Burdette - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Aug. 26, 2011 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 (Kan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** RESPIR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LLVVI ON 11) 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? perform 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Medical Certificate: To 1 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 🗷 Natural 5  $\square$  Pending Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 00062006

JW 1+1 State

Box 68760

P.O.

DHMH 17 Rev 7/2009

Registrar

MEDICAL GAMPUS

HAY GRITON N MIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALVALLO

31. Date filed (Month, Day, Year)

WIRSOM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death D914 August 2691.1 11:34PM Physician/ Britner Mae Barbara Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Williamsport 16912 Edward Doub Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 23,1939 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Maryland Months Days Hours Min. 1 🗆 M 2 🗓 F Director 215-36-6102 72 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2XXNo items 23a or 28a-f Williamsport Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21795 16912 Edward Doub Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2xxx No Specify: "natural", White 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Tax Preparer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked or any injury or other traumatic ever ပ္ Elizabeth Martin Wolford, Sr. Dortha William Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16912 Edward Doub Rd. Williamsport, MD William Britner - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Hagerstown Crematory Aug.25,2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) sbowne AumeradityHome, P.A. ignature of Funeral Sa 425 S. Conococheague St.Williamsport, MD 21795 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Nei Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv performed 2 🗌 No certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

mack

Medical Campus

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or									ible.		
	4	For State	State o	f Marylan		aπment ο <i>rtificate ο</i>			ental Hyو! ,	Reg. N			2891	6
		Registrar  1. Decedent's Name (First, Middle	e, Last)			Timouto o	Doda		2. Date of Dea	ith			3. Time of Dea	
Physician Medica		VINCENT J. BAIC	оссо						AUGUST	29		Year L 1	7:10 I	M
Examine		4a. Facility Name (if not institution				4b. City, Town	n, or Location	of Death			. County	of Death		
Europel	5	CHESTER RIVER F	OSPITAL C	ENTER 7. Age (In yrs. la	ast birthday)	If Under 1 Ye		er 24 Hrs.	8. Date of Birti	h	ENT		place (State or For	reign
Funeral Director		177-28-7320	1 <b>X</b> M 2 □ F	7.1.0- ( )	77 Yrs.	Months Da	ys Hours	Min.	07/07/	1934	4	PEN	ISYLVANIA	1
t ow		Usual Residence of Decedent  10a. State 10b. County		10c, Cit	y, Town or Lo	ocation							I 0d. Inside City Li	mits
anylar sa-f sh ified a	9010	MD KENT			LINGTO								1 XYes 2	] No
the N	Funeral Director	10e. Street and Number		HILL	IIIOIO.	10f. Zip Coo	de	· <del>-</del> · · ·		10g. Ci	tizen of V	Vhat Cou	ntry?	
h with	nera T	371 HURTT AVENU				21651				UNI		STAT		
2 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Mar</li></ul>	Armed Fo	dent Ever in U.S rces?		Was Decedent of If Yes, specify C	Suban, Mexic	an, Puerto				e - Amerio k, White,	ean Indian, etc.	
rs afte		3 ☐ Widowed 4 ☐ Divorced	If Voc Giv	e		1 🗌 Yes 2 🛣	No Specif	fy:			Specify:	WHI	re	
2 hour			nt's Education est grade completed)		(Give	dent's Usual Oc kind of work do	ne during mo	ost of work	ing	16b. K	and of Bu	usiness In	dustry	
ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	College (1	-4 or 5+)		OO NOT use retir				CO	NSTR	UCTI	ON	
iled w other vent, t	8 R	17. Father's Name (First, Middle, I	Last)		0015	IDH IMIO			e (First, Middle,	Maiden	Surname	e)		
Id be i Menta arked atic e	2	ALBERT BAIOCCO			1		MICH	ELIN	(UNKNO	WN)				
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations							al Route Numbe					
and and the Healt tem 2	-	JOANN BAIOCCO 20a. Method of Disposition	/ WIFE		Place of Disp	osition (Name of			INGTON,				own, State	
age 1 ent of nt: If i		1 Burial 2 X Cremation 4 Donation 5 Other (		State		UNTY CR		Y 9/2	2/2011	ATC	0. N	EW J	ERSEY	
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai any injury or other trai		21. Signature of Funeral Service I	Licensee \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	n 1 -	7 1	2. Name and Ac	dress of Fac	NBET	N & NEWN	IAM	FUNE	RAL	HOME, P.	Α.
20 E # 9		23a. Par 1. Enter the disease, or	)111.//2		1/ 1	30 SPEE	<u>r road</u>	CHES	STERTOWN	1, M	ARYL	AND	21620 Approximate	
		shock, or heart failure. List of Immediate Cause (Final	only one cause on ea	ich line.	)		aying, saon a	as calciac (	or respiratory arr	031,			Interval Between Onset and Deat	:h
Physician/ Medical		disease or condition resulting in death)	a. Due to	(or as a consequence	ac ac uence of):	rest				_		_	minute	2
Examiner		Sequentially list conditions,	b. 03	therosci	entie	: Heart	- Sin	ene	- 5/P M	NI.	recei	Thy.		
e ti	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	or as a conseq	uence of):				- /			0		
n and al-tran	Exal	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):									
⊕ # = .	lea		<b>L</b> d											
or Attending Physician: The law requires that the death certificate be after death.  Director: After this certificate has been signed by the attending physicii in by the funeral director, page 2 should be detached for use as the bu	_	IF FEMALE:	220 If yes out	come of pregna	ency						00   0			
eath certifica attending p	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 🔲 Live	Birth 2 Fet	al death 3	☐ Ectopic preg ☐ Other (specif						te of deli onth	/ery Day Year	
the de	lysi	9 🗌 Unknown	9 🗆 Unki									-		
requires that the de been signed by the should be detached		Part II. Other significant conditi											the cause of death	
require been si should	eted	O CHE GEN	d stage !	homey.	chsees	e on A	emva	dysis	24e W/aa				opsy findings avail	
sician: The law r certificate has b lirector, page 2 si	Completed by	3 Ironlin de	pendent	Dieleter	Mell	tus			l perio	psy ormed?		prior to c death?	ompletion of caus	e of
an: Th tificate tor, pa	Be C	25. Was case derred to medical	~			2	6. Place of D	eath (Chec		2 1	10	1 L Yes	2 No	
hysician: nis certific	일	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpati	ent 3 DOA	Other: 4 $\square$	Nursing H	ome 5 Resi	dence	6 🗆 Oth	er (Speci	5y)	
ding Physh. h. After this funeral di	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ilg .	of injury th, Day, Year)	28b. Time of injury		Injury at work? 1  Yes 2		28d. Describe h	now inju	ry occurr	red		
I or Attendir after death. Director: Af d in by the fu	Certificate:	2 Accident Invest 3 Suicide 6 Could 4 Homicide detern	mined 28e. Place			treet, factory, off		_ 140				er or Rur	al Route Number,	
rs afte al Dire ed in b	္ကီ	4 El Homicide Geteri	buildi	ing, etc. (Specif	y) 				City or Tov	vn, Stat	e)			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the to	Medical	(Check 2 Medical	g Physician: To the b Examiner: On the ba	sis of examination	on and/or inve	estigation, in my o	pinion, death	occurred a	at the time, date a	and plac	e, and du	e to the c	ause(s) and manne	r stated
io the other or the comple	ž	only one) 3 Certifying 29b. Signature and title of certified	g Nurse Practioner: er	To the best of m	ny knowledge		at the time, d cense numbe		ce, and due to th				Day, Year)	
		> ///www				i	021313	3		8	/30/	111		
8		30. Name and address of person	who completed cau				2/ 1							
RM		KIN K. WUN 31. Date filed (Month, Day, Year) AUG	MD 4/5	Wash	ington	Ane,	hester	lown	imD 2	162	0			
State Registra	e r	AUG	3 1 2011	Consuma.	, B.	park								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:40 AM Bi 99105 20 2011 Illiam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CATONSVILLE COMMONS CATONSVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F 09/19/1934 WASHINGTON D.C. 577-50-0530 76 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location show traumatic event, the Medical Evar-time must be notified at 1 ☐Yes 2 X No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23a or USA 21401 120 GRANVILLE AVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? or items 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 21X No Specify. Specify 2 WHITE 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALES INSURANCE AGENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOROTHY E. LINKINS WILLIAM J. BIGGINS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau once. 120 GRANVILLE AVE, ANNAPOLIS, MD 21401 DONZEL S. LOKER/FRIEND Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHESAPEAKE CENTER 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State CREMATION STEVENSVILLE, MD 08/25/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS, HELFENBEIN & NEWNAM CREMATION FUNERAL OF P.A. 814 BESTGATE ROAD, ANNAPOLIS, MD 21401 21. Signatural Funeral Service Dord. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Theimes /Medical Due to (or as a considuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the 9 D Unknown cate nas been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Tursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 23/11 muli-D47683

Lod

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 4 2011

Miller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Balhnere

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 27 Day Physician/  $0^{Month}$ 201 Tear 9:40 Claude Franklin Beckman рМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Co. Memorial Hospital Garrett 0akland If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1.▼ M 2 □ F Min. Hours 03 08 1924 Director 213-24-5178 87 MD Usual Residence of Decedent 23a or 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Mt. Lake Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a t may injury or other traumatic event, the Medical Examiner must be once. by Funeral 809 M St 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes 2
If Yes, Give
Year or Dates 2 No 1944 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White 3 Midowed 4 Divorced Specify: Completed 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 heavy equipment operator railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Beckman Leona Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Simms-daughter 809 M St, Mt. Lake Park, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Deer Park Cemetery 9/1/2011 Deer Park, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Burdock nd St undock 23a. Pary . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shrick, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 200 Medical resulting in death) Due to (or as a co **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) use > IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown signed by the a d be detached f P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signature should the 1 Yes 2 No 3 Probably 4 Unknown Completed Corcerous & 24b. Were autopsy findings available prior to completion of cause of death? s certificate has blirector, page 2 s autopsy performe 1 Yes 2 No 2. No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes Other: 2 No 1, Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 EResidence 6 Other (Specify) After this funeral 27. Manner 28a. Date of injury (Month, Day, Year) eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse P/actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month) Ç 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ames Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Huatts Thomas reorge If Und Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country Sh. 1 X M 2 □ F Months Hours DY Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Bashington DC 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Fairmont Street. NU 20009 EZ U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗡 No Specify. 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ 2009 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mith mont St N M 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town state 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sporter icensee Jenkins 20011 STN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 Y/S shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed ronic that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ abetes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pertersion autonsv Bilotera 2 🗌 No 1 Yes Yes Be Was case referred to medica 26. Place of Death (Check only one) examiner? 2 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011  $M \cup$ 

Registrar

State

Street

30¥

Irving

06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

3 2011

onth. Day

AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 28920 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SAMUEL EUGENE BROOKS SR. AUGUST 2011 1:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LARKIN CHASE NURSING HOME BOWIE Social Security Number 8. Date of Birth 1932 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Days 79 Months Hours Mir 577-40-2025  $\overset{\text{Year}}{20}$ AUGUST MARYLAND Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 No PRINCE GEORGE"S BOWIE MD 10g. Citizen of What Country 10e. Street and Numbe 10f. Zip Code ō ms 23a or must be r Funeral 4908 COLLINGTON ROAD 20715 USA permit. Page 1 and 2 should be filed within 72 hours after death to Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th GARDNER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES BROOKS ROSIE WELLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET E. BROOKS/WIFE 4908 COLLINGTON ROAD BOWIE, MARYLAND 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 8/26/2011 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Juneral Service License 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 ☐ Other (specify) Month Year Day Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown PARKERSON DISEASE 1 Tyes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🗷 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) (0) 1 Tes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: After t 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after death To the Funeral Director, completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State)

State Registrar

Medical

29a. Certifier (Check

only one 29b. Signature and title of o

3 [

30. Name and address of person

OKWARA M.D. 12200 ANNAPOLIS ROAD SUITE 316 GLENN DALE, MARYLAND 20769 IKECHI AUG 2 5 2011 32. Regis

impleted cause of death (Item 23a) (Type, Print)

Certifying Nurse Pray

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Mirse Practioner: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year) AUGUST 24, 2011

29c. License number

D43351

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/  $p_M$ 08 2011 5:38 Α. Blue Frances Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery <u>Fox Chase Rehab. & Nursing Center</u> <u>Silver Spring</u> 9. Birthplace (State or Foreign Country) Philadel Pennsylvania 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 🏻 F Months Hours 04/28/1951 **Director** 579-66-6444 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20011 USA 1406 Buchanan Street, NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Shipping and Receiving permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ John Adam Blue Frances May Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Buchanan Street, NW Washington, DC Sjovan Blue - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lincoln Cemetery 8/29/2011 4 Donation 5 Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. . Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD 20722 Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Myelogenous Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) n signed by the atten Id be detached for u in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 L Unknown Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Asthma page 2 autopsy this certificate has performed? Yes 2 X No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury X Natural 5 Pending e Funeral Director: Aft Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Scrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 8/23/2011 R169951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

John Husdon-Odoi

AUG 2 5 2011

C.R.N.P.

15245 Shady Grove Road Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	e of Maryland		rtment of H	ealth and Mei Death		ene 0   1	28922
	Dhysisi		Decedent's Name (First, Middle, Last)				2.	Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Buddy Buray  4a. Facility Name (If not institution, give street and			4b, City, Town, or	Location of Death	8	201 4c. County of Dear	
>	Examin		Johns Hopkins Bayview Me	· ·		Baltimore	Location of Death		40. County of Boa	
	Funeral Director		5. Social Security Number 212-64-3375 6. Sex 1 XXM 2	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Y	9. Bir 1952 Lur	thplace (State or Foreign untry) ay, VA
	D		Usual Residence of Decedent	10- 00-	Town or Loc					10d. Inside City Limits
	e Marylar Ba-f shov Iffled at	Director	WV Jefferson		pers					1XXYes 2 □ No
	th with the 23a or 2 st be not	ral Dire	10e. Street and Number 9 Michael Place			10f. Zip-Code 25425			g. Citizen of What Co USA	
36	be filed within 72 hours after death with the Maryland rial Hygiene. rial Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2XXMarried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. od Forces? Yes 2 <b>XX</b> No s, Give or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2【\\overline{X}\ov	spanic Origin? (Specif n, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify:	erican Indian, te, etc. <b>Vhite</b>
15-0036	2 hour aturali cal Ex	ted t	15. Decedent's Education		16a. Deced	ient's Usual Occup	ation during most of working	1	16b. Kind of Business	s/Industry
212	thin 7: e. Medii	Completed	(Specify only highest grade completed in the complete in the c	ge (1-4 or 5+)	life. L	OO NOT use retired	)		T	
212	led wi lygien her th it, the		12 17. Father's Name (First, Middle, Last)		Bus	Driver	18. Mother's Name (i		Transporta Maiden Surname)	ation
anc	eve eve	To Be	Ernest Franklin B	uracker			MaeBell	e Ross	en	
Maryland	shound M	۴	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Rural I	Route Number,	City or Town, State,	Zip Code)
	and 2 ealth a n 27 ls nertra		Cheryl Buracker - Wif				17, Harpers			
ore O	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal to	Tom otate		sition (Name of matory or other place			20c. Location - City o	
Baltimore,	permit. Pages Department of Important: If it any Injury or o once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	I Mt.	25	Cemetery Name and Addre	ss of Facility		Luray Vi	
ä	any and and and and and and and and and and	7	P. L. A. S.	In.	L	ackles-Sp arpers Fe	pencer & No erry, WV 2	orton F 25425	uneral Hor	ne 
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause		Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis						1 month
	Examiner			ue to (or as a conseque	ence or):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a conseque	ence of):					
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events C	ue to (or as a consequ	ence of:		_			
60,	te be executed ysician and he burial-transit		d							
9	rtificate ng phys s as the	Med	IF FEMALE:				_			
Вох	The law requires that the death certifica to has been signed by the attending photoge 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnar Live birth 2 ☐ Fetal Pregnant at time of de Unknown	death 3	_ Ectopic pregnanc _ Other (specify)	у		23d. Date of d Month	elivery Day Year
о. О	at the lby the letache		9 ☐ Unknown  Part II. Other significant conditions contributing		ulting in the	underlying cause o	iven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Records,	v requires that the de been signed by the a should be detached	ted by		ure				1 □ Ye		- V
9 0 0	law requas been 3 2 shou	Completed	Ischemic cerdi	omyopa	thy			24a. Was an autopsy perform	y prior to	autopsy findings available o completion of cause of
	rsician: The law certificate has b director, page 2 s		Acute respirator	y distr	222	syndron		1 ☐ Yes 2	2 X No 1 □ Ye	
Vital	sician certifi lirecto	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 Inpatient 2 □ E	ER/Outpatier	nt 3 DOA Oth	26. Place of Death (0 ler: 4 ☐ Nursing Home		nce 6 🗆 Other (Sp	ecify)
Division of	g Physer this	on: To	27. Manner of Death 28a.	Date of Injury (Month, Day Year)	28b. Time o		y at 28		w injury occurred	
SIO	ending   eath. or: After the fune	catic	2 Accident investigation				Yes 2 ☐ No	4 I4 (C4	hastand Number or	Pural Pauta Number
	I or Attending Physician; after death. Director: After this certifica I in by the funeral director,	Certification:	determined 200.	Place of injury - At hor building, etc. (Specify)		еет, тастогу, отпсе	28	Gity or Town	, State)	Rural Route Number,
_	Hospita 24 hours Funeral stely filled	edical C	29a. Certifier 1 Certifying Physician: 1 (check only one) 2 Medical Examiner: On and							
	o the vithin of the complex	Me	29b. Signature and title of certifier		_	29c. Licens	e number	25	9d. Date signed (Mo	nth, Day, Year)

10

State Registrar

backer

4940 Eastern Avenue, Baltimore, MD, 21224

MO

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

Orishne Via 31. Date filed (Month, Day, Year) AUG 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are legible. 28923 State of Maryland / Department of Health and Mental Hygiene Amend #14**1** - For State of Maryl Amend #14**1** - For Registrar FH, TCHD, pha 8/22/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Conwell Brittingham Medical 19 AM Augusl 1031 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memoria aston Talbot **Funeral** 7. Age (In yrs. last birthday, 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1**X** M 2 □ F Months Days Director 214-46-3868 10-30-1946 64 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Talbot Easton 1 X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funeral 29867 Standish Street 21601 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 Divorced 4 Divorced Specify: Black Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Mail Driver Transportation and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Brittingham traumatic Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 S. Brenda Brittingham (wife) 29867 Standish St. Easton MD 21601 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other 1 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\boxed{\mathbf{X}}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Woodlawn Memorial 4 Donation 5 Other (Specify) Park 8-26-2011 Easton, MD Signature of Funeral Service Licensee Fellows, Helienbein & Newnam Funeral Home P.A. MOHN R. MERCERO S. Harrison St. Easton MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Slebsiella disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions ner if any, leading to immediate Due to (or as a consequence of). Exami sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 🗌 No Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: After this of funeral dir 1/2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 14 Natural (Month, Day, Year) 5 Pending Director: A 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 6+VA State egistrar's Signatu

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 of Bradford Wayne Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner icomico tospic If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 X M 2 □ F Hours 1-29-1941 Maryland Director 216-38-8518 70 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Salisbury MDWicomico 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with ti Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o Funeral 21804 IISA 1608 Kaywood Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 X Married Yes, Give 2 No 1959-Maryland 21215-0036 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 1962 White Year or Dates any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company 4 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellis Edward Bradford Mary Louise Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Kaywood Drive, Salisbury, Maryland 21804 Betty B. Bradford - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State altimor 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gd. 8-16-2011 Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one car ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIOM YO Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ALVULAR Sequentially list conditions, Examiner Due to (or as a consequence of): any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death led by the a Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident ☐ Suicide ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 118 120 WATA 31. Date filed (Month, Day, Year) AUG 15 State

Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Man		partment of learning		id Menta	, 0	201		28925
			Registrar  1. Decedent's Name (First, Middle, La	st)		or timeate or	Douth	2. Da	te of Death			3. Time of Death
	Physicia Medic		Rheba	Р.	В	edsworth		Mo	onth & C	Oay V	ear (	1723 M
	Examin	er	4a. Facility Name (if not institution, give	· .	"	4b. City, Town, o	or Location of Do		4	c. County of		: -
	Funeral		5. Social Security Number 8.5		yrs. last birthda	If Under 1 Year	If Under 24 I	Hrs. 8. Dat	Date of Birth 9. Birthplace (State or Foreign			
	Director		213-36-2344	□ M 2 💢 F	74 Yrs.	Months Days	Hours M	Min. 12-	on <i>th, Day,</i> Year, -25-193	6	Count Mar	yland
	ind ihow at	or	Usual Residence of Decedent  10a. State  10b. County	10	c. City, Town or	Location					10	Od. Inside City Limits
	Maryla 8a-fs tiffied	Director	MD Wicom	ico	Sa1	isbury						1 ☐ Yes 2 🏋 No
	h the had a or 2 be no	al Di	10e. Street and Number	100	Dar	10f. Zip Code			10g. (	Citizen of Wha	it Coun	try?
	ath wit ms 23 must	Funeral	1407 Killarney D		:- 11.0		21804	2 (0:6 . )/	N -	USA		
9	er dea or ite miner	bу Fı	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☒ Married</li></ul>	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🏋 No	in U.S.	Was Decedent of If Yes, specify Cub	an, Mexican, Pu	erto Rican,	etc.)	14. Race - A Black, V		
003	urs aff :ural", al Exa	ted I	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 💢 No	Specify:			Specify:	Whi	te
5	72 ho n "nal	Completed	15. Decedent's I (Specify only highest g	rade completed)	(Gir	edent's Usual Occup e kind of work done DO NOT use retired	during most of	working	16b.	Kind of Busin	ess Ind	ustry
212	within giene. er tha , the I		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+		eacher	,		Wor	rcestei	r Co	unty
p	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		•		18. Mother's	Name (First,	Middle, Maide	n S <i>umam</i> e)		
Z	should be file n and Mental I 7 is marked o raumatic eve	-	Charles	Е.	Pa1		Jenny		Ε.		Smit	
Ma	12 shoulth an an and an an an an an an an an an an an an an	9	19a. Informant's Name/Relationship (			iling Address (Street 7 Killarne			*			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 3	20a. Method of Disposition	2	20b. Place of Dis	position (Name of ematory or other pla	1	Date		Location - Cit		
Ë	Page 1 ment of tant: If it tury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr			Cemetery	· · · · · · · · · · · · · · · · · · ·	3-17-20	011 Sa	lisbur	у,	Maryland
Ball	permit. Page Department I Important: Il any injury or		21. Signature of Funeral Service Licen	11 P P	\	22. Name and Addre			s Fune			
			23a. Part 1. Enter the disease, or com	polications that caused the		705 E. Ma				y, Mary	/lan	Approximate
	Physician/		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.		-,-	.9, 040.		,			Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a co							+	
	Examiner	Ē	Sequentially list conditions,	b. —							4	
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):							
	execut in and ial-trai	Exa	that initiated events resulting in death) Last	C. Due to (or as a co	nsequence of):		_				+	
09	te be e nysicia ne buri	dical		d								
687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	/We	IF FEMALE:	23c. If yes, outcome of p	rognanov							
Box	attence attence for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 4 Pregnant at tim	Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date o Month		ry Day Year
0.0	that the death ned by the atte detached for	hysi	9 Unknown	9 Unknown								
	ss that igned be det	þ	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying cause gi	ven in Part I.	23				e cause of death?
<u>rd</u> s	law requires nas been sign s 2 should be	eted						_				ably 4 Unknown
မင္ပ	as as	Completed						24	la. Was an autopsy performed2	prio	r to con	sy findings available npletion of cause of
<u>=</u>	sician: The law scrifficate has birector, page 2 s	Be Co	25. Was case referred to medical			26. P	lace of Death (C		Yes 2	No 1	Yes 2	2 No
	hysici his cer I direc	일	examiner?	Hospital: Inpatient	2 ER/Outpat	ent 3 DOA Oth	ier: 4 🗆 Nursin	ng Home 5[	Residence	6  Other (5	Specify)	
10	al or Attending Physis s after death. Il Director: After this ced in by the funeral director.		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Ye	28b. Time injury	wor	k?	- 1	scribe how inju	ary occurred		
SIOI	Attenc r death ctor: y the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined		At home, farm,		Yes 2 No		cation (Street a	and Number o	r Rural	Route Number
Division of Vital Records,	tal or v s after al Dire		4 ☐ Homicide determined	building, etc. (S		,,,			y or Town, Stat		rarari	Todas Nambol,
	To the Hospital or Attending Physician; The I within 24 hours after death.  To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	(Check 2 \( \sum \) Medical Exam	sician: To the best of my liner: On the basis of exami	ination and/or inv	estigation, in my opini	on, death occurr	red at the time	e, date and place	ce, and due to	the caus	se(s) and manner stated.
	To the vithin to the comple	Ž	only one) 3 ☐ Certifying Nur 29b. Signatuje and title of dertifier	se Practioner: To the best	t of my knowledge	e, death occurred at the	e time, date and e number	d place, and c	due to the cause	e(s) and manne late signed (M	er as stat	ted.
			) year			063	3199.			12/11.	,	
	373		30. Name and address of person who	completed cause of death  910 CAS  32. Redistrar's S	(Item 23a) (Type	Print) SHORE BR	-, SAL	LISBUR	Y, MD	2180	Ч,	
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature _	1 1	<u> </u>					·
	Registra	ır	AUG 15	CUII Janear	UB.	par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bradle nomas Medical 110. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ohrs Hopkins alh More Cit 9. Birthplace (State or Foreign Country) Maryland Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Firth Months | Days | Hours | Min. (Month, Day, **Funeral** Social Security Number Days 1 X M 2 F 220-68-8472 54 Director 06/27/1957 Usual Residence of Decedent show 10h County with the Maryland at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f Wicomico Mardela Springs 1 X Yes 2 No Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 207 Church St. 21837 items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ŏ ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Corrections Officer Division of Corrections Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of ဂ Violet Greene Lou Gehrig Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ment of Health a 207 Church St., Mardela Springs, MD 21837 Gale L. Bradley/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mardela Memorial idjury or 8/18/2011 Mardela Springs, MD Donation 5 Other (Specify) Cemetery unatu Dep mp any i 22 Name and Address fife all Home Professional Association . 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ omol ete disease or condition Medical resulting in death) Examiner ronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi Wor and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Was an page 2 s 25. Was case referred to medica funeral director, 26. Place of Death (Check only one, Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 M No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury **✓** Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 201

Registrar

DHMH 17 Rev 7/2009

State

saltimore

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06231 State of Maryland / Department of Health and Mental Hygiene William Thomas Cole Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1644 hrs August 18, 2011 Medical Examiner William Thomas Cole 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days Hours Director Country) Maryland 08/06/1969 1 X M 2 F 42 213-04-0393 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 1 Yes 2 X No Maryland Calvert North Beach with the Maryland Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20714 3700 3rd Street 238 14. Race - American Indian, Black, uneral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Y Married 2 X No Yes ũ If Yes, Give Yeer or Dates: 1 Yes 2 X No specify: Specify: White 3 Widowed 4 Divorced 至 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages I and 2 should be filed within 72 hours in nent of Health and Mental Hygiene, and I item 27 is marked other than "natura yr other traumatic event, the Medical Examination." 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Compl Construction Construction 12 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) B Richard Cole Margaret Ann Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 3rd Street, North Beach, Maryland 20714 Belinda Sue Cole / Wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 08/23/2011 Port Republic, Maryland Chesapeake Highland Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Rausch Funeral Home, PA. 4405 Broomes Island Road, Port Republic, Maryland 20676 Kyle S. Simons MO1206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. (Medical Death a. Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and tran Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year I ive birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown jo 9 Unknown the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ğ Atherosclerotic Cardiovascular Disease Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of has performed' 2 No page ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Other Nursing Home 5 Residence 6 Other this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury 28b. Time of Injury After Aug 18, 2011 Subject drowned 1541 hrs 1 Natural 1 Yes 2 V No 5 Pending -death 2 🗸 Accident Investigation in by 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Chesapeake Bay, North Beach, MD (Specify) Bay the Hospital 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number August 19, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 5 KW Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD AUG 2 4 201 32. Registrar's Signature State Registra

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 Physician/ 5:45 P M August Lillian H. Coates Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 910 President St. Apt B2 Annapolis g. Birthplace (State or Foreign New York 8. Date of Birth Jay, 4 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral Days Hours 1 □ M 2 🔽 F 1938 73 212-38-3917 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2X No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21403 910 President St. Apt B2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mariant once. ural", or iter Armed Forces?
1 ☐ Yes 2 🌠 No Black White, etc. ş 1 Never Married 2 Married 1 ☐ Yes 2√√ No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Annapolis Elementary/Seconday (0-12) College (1-4 or 5+) Nursing & Rehab 11th Nursing Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Paulena Leggette William Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21401 23 Annapolis, Bates St. Lillian Studevent(Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20pj Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8-23-11 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens Miname Recessor RollinSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annapolis, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to a consequence of): cause. Enter underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached t g | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number rson who completed cause of death (Item 23a) (Type, Print) Sie ANDAL

State Registrar th, Day, Year) AUG 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 10:03 PM Richard Clark August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Severna Park <u>Sunrise Assisted Living</u> If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months New York 1 XM 2 AF Hours 097-14-1186 88 June 01, 1923 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ Director Examiner must be notified Severna Park Anne Arundel 1 Yes 2 X No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 23a Funeral USA 21146 114 McKinsey Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1940 Black, White, etc. "natural", or ۾ 1 Never Married 2 Married Maryland 21215-0036 White 1944 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Distribution Center Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ Mary Coyle Earl Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1463 Falcon Nest Court Arnold, MD 21012 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gail Mahan/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date August 19, 2011 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, INC. Baltimore, MD 4 Donation 5 Other (Specify) P.A. Severna Park Funeral House Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee Home 23a. Part 1. Enter the Bease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Phylician emention disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last burial Physician/Medical that the death certificate be Box 68760 attending ph d for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? MSSISTED LIVING Other: 4 Nursing Home 5 Residence 6 1 Yes 2: No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

DHMH 17 Rev 7/2009

State

3+1

29b. Signature and title of certifier

31. Date filed (Mo.

money

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 3 2011

8601

29c. License number D57531

Ve tering Mesy Suite Less

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janet Ann Cullum 350 M Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏲 F Months F@B". D18Year)1936 219-32-6813 75 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Grantsville 1 Yes 2 X No MD Garrett 10e. Street and Number ō 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 21536 USA 13941 National Pike 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than Elementary/Seconday (0-12) life. DO NOT use retired) h and Mental Hygiene.
If is marked other than traumatic event, the M College (1-4 or 5+ Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ of Health and Ments fitem 27 is marked rother traumatic e Thelma Jenkins Salvy Coscia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 West Howard St., Hagerstown, MD Shawn A. Wolfe/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or oti 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Grantsville Cemetery Aug. 30, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility · Luce euma P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or s a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death is certificate has been signed by the a director, page 2 should be detached Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by arcinoma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 🗌 Yes ဂ 1. Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 
Yes 28d. Describe how injury occurred 1.Æ Natural injury 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the fi Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Box 68760

Medical

29a. Certifier

(Check only one) 29b. Signature and title

State Registrar

Gupta, 625 Kent Ave., Cumberland, MD 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

istrar's Signature

1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated partitiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DO0 33280

21502

29d Date signed (Month, Day, Year) 29

2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Ma	-	artment of Heal <sup>.</sup> tificate of Deat	th and Mental Hyo th	giene Reg. N. 2011	28931
	Physicia		Registrar     Decedent's Name (First, Middle, Last)     Donald Ellwood Combs			2. Date of Dea		3. Time of Death 1734 M
	Medic Examin	al	4a. Facility Name (if not institution, give street and number) WM. Regional Medical Center		4b. City, Town, or Local	tion of Death	4c. County of Death Allegan	1
our of the same of	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) 33 Yrs.		nder 24 Hrs. 8. Date of Birt	th 9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent		etion	l lubiti	4 1320 Nese	10d. Inside City Limits
	karyland Ba-f sho tified al	Director	10a. State 10b. County Allegany	10c. City, Town or Loc Bart				1 Yes 2 X No
1	with the iv	Funeral Di	10e. Street and Number 17745 Pekin St. SW, PO Box	215	10f. Zip Code 21521		10g. Citizen of What Co United Sta	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the waryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Wildowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 □ If Yes, Give K year or Dates.	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.) ecify:	14. Race - Amel Black, White Specify: W			
Maryland 21215-0036	tnin 72 noui ane. <b>than "natu</b> <b>he Medical</b>	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5-  unknown	(Give I	dent's Usual Occupation kind of work done during O NOT use retired) Lenance Man	most of working	16b. Kind of Business Steel Manuf	
land 2	be nied wir ental Hygie <b>ked other</b> ic event, th	To Be (	17. Father's Name (First, Middle, Last)  Lory Combs		18. 1	Mother's Name (First, Middle, Pearl Comb		
Mary	12 should atth and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type, Print) Roy Droll/ nephew	19b. Mailir 1952	ng Address (Street and N. New George	umber or Rural Route Numbe es Creek Road	er, City or Town, State, Zin Barton Mai	ryland 21521
Baltimore,	Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo		y 09/01/2011	20c. Location - City or Bloomingtor	
Balti	permit. Departing Importa any inju		21. Signature of Funeral Service Licensee			Facility Boal Fune: t, Westernport		21562
p	nysician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate Cause (Final	the death. Do not enter.	er the mode of dying, suc	ch as cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. Du to (or as a	a consequence of).	al porty			
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a consequence of):				
	cate be executed physician and the burial-transit	al Exa	that initiated events C	a consequence of):				
1260	cate by physical properties of the part of	<b>ledical</b>	d					
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
ls, P.O.	ures that the signed by a detac	ed by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause given in	1	tobacco use contribute to	
Division of Vital Records,	ine iaw requate has beer bage 2 shou	omplete				24a. Was auto perfi 1 □ Yes	opsy prior to death?	utopsy findings available completion of cause of s
tal	clan: Sertifica ector, p	Be	25. Was case referred to medical examiner?		Othor	of Death (Check only one)		
n of Vi	aing Physi h. After this o funeral dir	ate: To	27. Manner of Death 28a. Date of inju 1 Natural 5 ☐ Pending (Month, Da)		nt 3 □ DOA 4		idence 6 U Other (Spec how injury occurred	cify)
ivisio	or Attenated after deat Director:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inju-	ury - At home, farm, str c. (Specify)		28f. Location (	(Street and Number or Ruwn, State)	ıral Route Number,
	e Hospital 24 hours e Funeral leted fillec	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of e	xamination and/or inves	stigation, in my opinion, de	eath occurred at the time, date	and place, and due to the	cause(s) and manner stated.
	vithir To the	2	29b. Signature and title of certifier	~	29c. License num		29d. Date signed (Mont	
	, , \	A	30. Name and address of person who completed charge of d	leath (Item 23a) (Type,	Print)	/ / / / / / / / / / / / / / / / / / /	8-28-11	
	5+1		Dr. Christopher Vagnoni,	925 Seton	Drive, Cumb	eriand, MD 2	1502 ——————	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registry  AUG 2 9: 2011	ar's Signature	Signal !			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			For State Registrar		State of	iviai yiai i		tificate of l		Wentarry	Reg. N2	011	28932
	Dhariaia	/	1. Decedent's Name (		, Last)					2. Date of De	eath	Vear	3. Time of Death
	Physicia Medic		MONTGOME		CORNWELL					AUGUST		201 Tear	5:54 Рм
	Examin	er	4a. Facility Name (if no			er)			r Location of Dea	th		County of Death	
			Bradford  5. Social Security Num			. Age (In yrs. I	act hirthday)	Clinton If Under 1 Year	If Under 24 Hrs	s. 8. Date of Bir		ince Ge	orge's place (State or Foreign
	Funeral Director		577-70-414 Usual Residence of De	9	tx□ M 2 □ F	58	Yrs.	Months Days	Hours Min		ay, Year)	Coun	DC DC
	and show 1 at	ō		0b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryl 28a-f otifiec	Director	MD	Princ	e George's	Cli	nton				_		1 🔀 Yes 2 🗆 No
	a or a	Q E	10e. Street and Numb					10f. Zip Code			10g. Citize	en of What Cour	ntry?
	h with	nera	7520 Surr	ants				20735				d States	S
	deat riten ner r	교	11. Marital Status		12. Was Deced	ces?	S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14	<ol> <li>Race - Americ Black, White,</li> </ol>	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	1 Never Married		If Van Civa			☐ Yes 2 H No	Specify:		Sp	pecify: Blad	ck
15-	72 ho "nat	nple	(Specin	y only highe	nt's Education est grade completed)		(Give	lent's Usual Occup kind of work done	during most of wo	orking	16b. Kind	d of Business Inc	dustry
12	vithin jene.  r thar the M	S	Elementary/Secon	day (0-12)	College (1-4	1 or 5+)	l	O NOT use retired) tenance		an	Fodor	ral Gove	arnmant
	filed vall Hyg	Be	17. Father's Name (Fir	st, Middle, L	.ast)					ame (First, Middle			
Иал	d be Menta arkec	은	Martin C	ornwe:	11				Katie	M. Hunt	er		
Maryland	shoul and is m		19a. Informant's Nam	e/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	er, City or To	own, State, Zip C	Code)
	and 2 Health em 27 ther t		Cynthia C 20a. Method of Dispos	ornwe	ll/Wife	20h F	736 1	Mentor Av	e,Capito	ol Heigh		D 20743 ation - City or To	Dum Stata
Baltimore,	nt of 1 nt of 1 t: If it		1 Burial 2 😾	Cremation	3 Removal from S	State C	emetery, cren	natory or other pla				•	
Ē	nit. Pa artme ortan injun		4 ☐ Donation 5  21. Signature of Fune			Riv	erdale	Park Cre  . Name and Addre	ematory ss of Facility PO	8/23/201 PE FUNES	L Rive	erdale,	Maryla <u>nd</u>
Ba	permi Depar Impoi any ir		Vant	and	Euce M	0108		538 MARL				-	
			23a. Part 1. Enter the	disease, or	complications that ca	used the deat	h. Do not ente	er the mode of dyir	ıg, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Prysician		Immediate Cause (Fir disease or condition		Na	1 Insu	Liv De	redent	Dinted	les .			Onset and Death
-	Medical Examiner		resulting in death)	4	Due to (o	r is a consequ	ience of):	. 00	F / ./	Rule	0 1.4		
		er	Sequentiary list cond	itions,	t. Pue to (o	r as a consequ	lence of:	ic Prip	my VX	Kullen	U BU	re	
	red	Ϊ	Eequentiany list cond if any, leading to imm cause. Enter Underly Cause (Disease or iin	ing iury	Due to (o	as a consequ	derice oi).						
	execut in and ial-tra	Exa	that initiated events resulting in death) La		C. Due to (o	r as a consequ	uence of):						
8	sate be executed physician and the burial-transit	Medical Examiner			d								
8760	tificat ng ph as th	Mec	IF FEMALE:		1			=27000					
39 ×	attending p	jan/	23b. Was decedent pr in the past 12 mg			irth 2 - Feta	al death 3	Ectopic pregnan	су		23	3d. Date of delive	ery Day Year
Box	Attending Physician: The law requires that the death certificate be executed in death.  **r death.**  **setor: After this certificate has been signed by the attending physician and setor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	1 Yes 2 9 Unknown		4 ☐ Pregn. 9 ☐ Unkno	ant at time of o	death 5 L	Other (specify) _				WOILI	Day
P.0	ires that the dea signed by the a Id be detached f		Part II. Other signification	ant condition	ons contributing to de	ath but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use	e contribute to th	ne cause of death?
	uires t n sign ald be	Completed by								. 10	Yes 2	Prol	bably 4 🗆 Unknown
Records,	w require s been s 2 should	plet								24a. Was		24b. Were auto	psy findings available mpletion of cause of
Rec	sician: The law certificate has irector, page 2 9	E O				-				perf	ormed?	death?	_
Vital	sian: ertifica cctor,	Be (	25. Was case referred examiner?	to medical					lace of Death (Ch	eck only one)			
Ž	Physic this or al dire	은	1 🗆 Yes 2 🔍	No		npatient 2 🗆			4 LarNursing	Home 5 Res			2
u of	ding F th. After funer	ate		5 Pendin	9	injury n, Day, Year)	28b. Time of injury	wor		28d. Describe	how injury a	occurred	
Siol	er deatl ector: by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could determ	not be	of Injury - At ho	ome, farm, str	eet, factory, office	1 163 Z LL 140	28f, Location (	Street and I	Number or Rural	l Route Number,
Division	al or Att s after d al Direct ed in by		4 LI Homicide	determ	building	g, etc. (Specify	)			City or To			
_	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2	Medical E	Physician: To the be examiner: On the basis Nurse Practioner: To	of examination	n and/or invest	tigation, in my opini	on, death occurred	d at the time, date	and place, a	and due to the ca	use(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and titl			o the best of m	y Itriowieage, t	29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	)		> We	le 1	/ Clerca 1	7		D3	5206		H	ugu. L	22,2011
2	_3		30. Name and address	of person	who completed cause	/ .	23a) (Type, F	701 CN	1 upstra	Rond,	Fat	WASH ,-	22,201/ 1tm. M2
	Stat		31. Date filed (Month, AUG 2 3	Day, Year)	32. Re	gistar's Sign	ture		<del></del>				<del></del>
	Registra	all.	MUU Z 3	PALL	manage !	~. <i>[</i> ]	-						

		_ For	Please	• •		Depa	rtment of H	lealth and		Are Legible	289	133
Physicia			ne (First, Middle, La	st)			tificate of I	Death	2. Date of Dea	Day Yea	3. Time o	of Death
/Medic	al	Charle		ve street and number)	C	arder	4b. City, Town, or	r Location of Dea	Sep	1, 2011 4c. County of De		PM™
Examin	er		n Living C				Cumb	erland		Allega	ny	
Funeral Director		5. Social Security N 217-30-	-2111	Sex 7. Ag	e (In yrs. last 76	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		<sup>th</sup> y, Year) 9. B 1, 1934	irthplace (State Country) MD	or Foreign
Maryland f show		Usual Residence o  10a. State  MD	10b. County Alleg	any	10c. City, To		cation town				10d. Inside 0	City Limits
or 28a-	Director	10e. Street and Nu					10f. Zip Code			10g. Citizen of What 0		
eath wi	la l		South P.0	D. Box 67	Ever in IIS	13 (	Mas Decedent of H	21555	Specify Yes or No	14. Race - Ar	A nerican Indian,	
irs after de il", or item	by Fun	<ol> <li>Marital Status</li> <li>Never Mari</li> <li>Widowed</li> </ol>	ried 2 ☐ Married	Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of H fYes, specity Cuba I∐Yes 2 ☑ No	Specify:	rto Rican, etc.)	Black, Wh		
72 hou	Completed	(Spe	15. Decedent's E	ducation ade completed)	- 11	(Give	dent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of Busines	s/Industry	
within jene. r than	dwo	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)	Labo	DO NOT use retired D <b>rer</b>	a)		Construct	ion	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expeditions and the rediffied at once.	To Be C		(First, Middle, Last		,				eme <i>(First, Middle,</i> E. Athey	Maiden Surname)		
ind 2 shou alth and N 27 Is mai		19a. Informant's N George	Name/Relationship (	(Type. Print)	end	19b. Mailir P.	ng Address (Street O. Box 16	and Number or F	Rural Route Numb	er, City or Town, State	e, Zip Code) MD 21	1555
iges 1 and of the street of other		20a. Method of Dis 1 ☐ Burial 2		Removal from State	cem	etery, cřen	sition (Name of matory or other place uneral Hom		Date 9/5/2011	20c. Location - City  Cresap		MD
ermit. Pa mpartme mportant ny injury			5 ☐ Other (Speci uneral Service Lice		Ocar	·	2. Name and Addre	elli Funeral	Home, PA			IVID
207.60		23a. Part 1 Enter	the disease, or com	nplications that caused	d the death. (	Do not ent		*		land, MD 21502 rrest,	Approxim	ate
Physician /Medical Examiner		shool or hea Immediate Cause disease or condition resulting in death)	(Final on		ne.  ( ) O O O O O O O O O O O O O O O O O O						Interval B Onset and 2	d Death
be executed be executed burial-transit	cal Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease of that initiated event resulting in death)	lS	c	a consequen	,						
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr	2 months?	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal de	eath 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of Month	delivery Day	Year
quires that n signed build be deta	by		ificant conditions	contributing to death b	out not resultin	ng in the u	nderlying cause g	yen in Part I.	23e. Did	tobacco use contribute Yes 2 ☐ No 3 ☐	e to the cause o	
The law rec te has bee age 2 shou	Completed						8		24a. Was - auto perfo	an 24b. Were prior death 22 No 1 🗆	autopsy finding to completion o	gs available f cause of
iclan: sertifica ector, p	Be C	25. Was case refe examiner?	1 -	Lloopitols			Oth		eath (Check only			
g Phys er this eral dir	n: To	1 ☐ Yes 2 ☐ 27. Manner of Dea		28a. Date of Inju	ent 2 ER	Bb. Time o	nt 3 🗆 DOA	- 1 -		idence 6 Other (5 how injury occurred	pecify)	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ertification:	Natural 2 Accident 3 Suicide	5 ☐ Pending investigation 6 ☐ Could not be determined	28e. Place of In	jury - At home	Injury e, farm, str		Yes 2□No	28f. Location	(Street and Number of	· Rural Route N	umber,
Fo the Hospital or within 24 hours afte To the Funeral Dir	O	4 ☐ Homicide  29a. Certifier	Certifying P		tc. (Specify) of my knowle	edge, deat	h occurred at the t	ime, date and pla		e cause(s) and manne	r as stated.	
the Hos hin 24 h the Fur npletely	Medical	(Check only one)	2 Medical Exa		of examination		nvestigation, in my	opinion, death or		, date and place, and	due to the cause	
To with	2	29b. Signature and	d title of Certifier	ylur			29c. Licens	0.0-	٥'د	29d. Date signed (M	2 011	
108		SUNIL	GrupTI	completed cause of	death (Item 23	3a) (Type,	Print) Ave. St	he.101	Cumbe	rland, Mi	D ais	502
Sta Registr		31. Date filed (Mo	2 2011	32. Regist	ra's Signatur	e	Total Control			•		
HMH 17 Rev 1/2		3	- 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 l 17:38 PM Cordial Paul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cumberland Allegany WMHS-RMC Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 □ F North, Day MD Director 215-26-6854 80 Usual Residence of Deceden rral", or items 23a or 28a-f show Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Cresaptown 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12817 McKay Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced white Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tire Finisher Tire Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lillian Eisentrout Martin Cordial 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12817 McKay Avenue Cresaptown MI permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Earlene Cordial MD 21502 wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Michael's Cemetery 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/5/2011 4 Donation 5 Other (Specify) Frostburg MD Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequer Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

32. Redistrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28935 Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ALDA JUNE CARR 2011 7:50 a. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lonaconing Allegany Egle Nursing Home If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days June 8, 1917 Months Hours Min. 94 Rawlings, MD 219-03-9400 Director Usual Residence of Decedent 28a-f show 10a. State be filed within 72 hours after death with the Maryland items 23a or 28a-f sho er must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Allegany Rawlings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23501 McMullen Highway, S.W. 21557 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ?7 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 X Widowed 4 □ Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Textile Manufacturing Coning Department Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ William E. Iser Julia Catherine Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Alda K. Westfall/Niece P.O. Box 221 New Creek, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Dawson, Maryland Dawson Cemetery Signature of Funeral Service License Smith Funeral Home 22. Name and Address of Facility 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CERERRO VACCULAR Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin physician and the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a g . Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should page 2 Certificate: To

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital Division

DEMENT	if C	ONCESTI	VE HEART	1 🗌 Yes 2 🗆	☐ No 3 ☐ Probably 4 ☐ Unknown
	· · · · · · · · · · · · · · · · · · ·	F	4 LURE	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of Death (Chec	k only one)	
1 ☐ Yes 2 PNo	Hospital: 1  lnpatient 2	BR/Outpatient 3 □ I	DOA Other: 4 Nursing Ho	ome 5 Residence 6	Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury		28d. Describe how injury	
3 Suicide 6 Could not I 4 Homicide determined			ry, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 Certifying Phy	vsician: To the best of my know	vledge, death occured	at the time, date and place, ar	nd due to the cause(s) and	manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Ju645

21502

2011

29c. License number

To the within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road Cumberland, MD Harjit Sidhu, M.D.

31. Date filed (Month, Day, Year) State Registrar

Medical

only one) 29b. Signature and title of certifier

0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	aryland		artment of H tificate of D		Mental Hy	giene Reg. N	01		28936
	Physicia	n/	1. Decedent's Name (First, Middle, Las	,					2. Date of De Month	eath		ar	3. Time of Death
	Medic	al	Walter B. Chicos  4a. Facility Name (if not institution, give	7					08				21:45P M
	Examin	er		street and number)			4b. City, Town, or E1kton	Location of Dea	ith *	4c. 0	Cec		
	Funeral		Union Hospital  5. Social Security Number  6. Se	7. Age	(In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth	9.		ace (State or Foreign
gris.	Director		217-05-4133 Usual Residence of Decedent	LACIVI 2 LI F	96	Yrs.	Monaio Days	710010	2/21/	1915		Oourin	MD
	land show d at	tor	10a. State 10b. County		10c. City	, Town or Loc	cation					10	d. Inside City Limits
	Mary 28a-f iotifie	irec	MD Cecil		E1k	ton							1 🗆 Yes 2 🔀 No
	ith the 3a or t be r	ralD	10e. Street and Number				10f. Zip Code				en of What	Count	ry?
	ems a	Funeral Director	244 Hutton Road	12. Was Decedent E	ver in U.S.	. 13. V	21921 Vas Decedent of His	spanic Origin? (	Specify Yes or No	USA 1	A 4. Race - A	merica	n Indian
9	fter de , or it amine	by	1 🔀 Never Married 2 🗌 Married	Armed Forces?  1 1 Yes 2 1  If Yes, Give		1f	Yes, specify Cubar Yes 2 😾 No	n, Mexican, Pue	rto Rican, etc.)		Black, W	hite, e	tc.
Š	ours a atural' cal Ex	Completed	3 Widowed 4 Divorced	Year or Dates.	1941-	-45					Specify:		/hite
ر د ائ	n 72 h e. an "na Medi	du	(Specify only highest gra	de completed)  College (1-4 or 5-	.,	(Give k	ent's Usual Occupa kind of work done do O NOT use retired)	uring most of w	orking	16b, Kin	d of Busine	ss ind	ustry
7	f withi ygiene her th it, the		8		*)	We1d	er			Dre	dge_Co	omp	any
and	oe filec intal H ced ot ced ot	To Be	17. Father's Name (First, Middle, Last)  Samuel Chicosky						ame (First, Middle a Kulchu		ırname)		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. ' is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street a				own. State.	Zip Ci	nde)
	alth a n 27 is er tra		Stephen Chicosky	- nephew			utton Roa						,
saitimore,	age 1 and 2 should be int of Health and Menta t: If item 27 is marked r or other traumatic e		20a. Method of Disposition 1   → Burial 2   → Cremation 3   →	Removal from State	20b. Pl	ace of Dispos metery, crem	sition (Name of natory or other place		Date	i	ation - City		
	tre tran		4 ☐ Donation 5 ☐ Other (Specify 21. Signa uneral Service Lices	)	St.		Lima Cem.						City, MD
n	Depar Depar Impor any ir		21. Signal Juneral Service Licens	U Zh			Name and Address 59 East M						
	4		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused ne cause on each line.	the death							17	Approximate Interval Between
1	Medical		Immediate Cause (Final disease or condition resulting in death)	a ACUT		RENA	L FAI	LURE					Onset and Death
	Examiner		resulting in death)	Due to (or as a	conseque	ence of): ATION	/						
	<u> </u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	1 -	<u> </u>							
	rcuted and transit	xam	Cause (Disease or linjury that initiated events	C. — —								_	
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a	conseque	ence or);							
2/00	fficate ig physas the	_	is service	a									
20 X	th cert tendin or use	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Petal	death 3	Ectopic pregnancy	,		23	3d. Date of		<i>'</i>
. Box	r the at	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5∟	Other (specify)				Month	ı	Day Year
7. O	that the	by Pt	Part II. Other significant conditions co	ntributing to death bu	ıt not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did 1	obacco us	e contribute	to the	cause of death?
ds,	quires en sign	ted t							1 🗆	Yes 2	] No 3 [	Proba	ably 4 Unknown
ecords,	law re has be e 2 sho	Completed							24a. Was	psy	prior	to com	sy findings available npletion of cause of
ב	n: The ficate n; pag		25. Was case referred to medical						1 🗆 Yes	2 No	death		2 🗆 No
	ysicial s certi directo	To Be	examiner?	lospital:	nt 2 🗆 E	R/Outpatient	Other	ce of Death (Ch	eck only one)  Home 5 🗆 Resi	donce & [	Other /Sr	naciful.	
5	ng Ph fter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	/ 2	28b. Time of injury	28c. Injury work?	at	28d. Describe			<i>эеспу)</i>	
5	ttendi death. tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆 Y	/es 2□No					-11-1-1
DIVISION OF	al or A s after I Direc d in by	ခြ	4 Homicide determined	28e. Place of Injur building, etc.		ne, tarm, stre	et, factory, office		28f. Location ( City or Tox		Number or i	Rural F	loute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examin	ner: On the basis of exa	amination	and/or investi	gation, in my opinior	n, death occurred	at the time, date	and place, a	and due to th	ne caus	se(s) and manner stated.
	To the vithin 2 to the comple		only one) 3 Certifying Nurs  29b. Signature and title of certifier	e Practioner: To the b	est of my	knowledge, d	eath occurred at the 29c. License		lace, and due to the		and manner signed (Mo		
			1////	(MD			DO	03486	,		UST, a		
	5		30. Name and address of person who on NATHAN HAMARE 31. Date filed (Month, Day, Year)	ompleted cause of dea	ath (Item 2	23a) (Type, Pr	T, ELKT	W. MI	21921				
	Stat	е	31. Date filed (Month, Day, Year)	32. Redistrar	's Signatu	re	a Kas	J. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. [-]				
	Registra	r	AUG 2 9 2	UIII Dense	w,	p. 49	Was -						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar		artment of H		,	001	1 28937
			Registrar  1. Decedent's Name (First, Middle, Las	t)	06/	uncate of D	Gairi	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia Medio		Samantha		Car	roll		Augus	t 16 2011	0705 M
	Examin	er	4a. Facility Name (if not institution, give		0.14.0	4b. City, Town, or I	Location of Deat	h	4c. County of	
	Funeral		5. Social Security Number 6. Se	1-16-016-0-	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt		Birthplace (State or Foreign
	Director			□ M 2 XF 23	Yrs.	Months Days	Hours Min.	11-20-		Country) Iaryland
	nd now at	Ļ	Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	cation				
	arylar ba-f st	ecto	MD Wicomic		Salis					10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	or 28	Funeral Director	10e. Street and Number	.0	Salis	10f. Zip Code			10g. Citizen of Wha	
	s 23a	nera	6491 Levin Dashie	11 Road		21	801		USA	
	r death r item iner n	/ Fui	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Sp., Mexican, Puert	oecify Yes or No- o Rican, etc.)		American Indian, White, etc.
920	be filed within 72 hours after death with the Maryland and Hygiene. Red other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates.		☐ Yes 2 💢 No	Specify:		Specify: V	
2-0	hour natur dical	Completed	15. Decedent's Ed (Specify only highest gra	lucation		lent's Usual Occupat		4.2	16b. Kind of Busin	ess Industry
2	thin 72 ne. than '	om	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done du O NOT use retired)		KING	0.11	
Ö Ö	ed wil Hygie <b>other</b> ent, th	ВеС	12 17. Father's Name (First, Middle, Last)			Studen	-	no (Eirot Middle	College Maiden Surname)	
lan	l be fil fental rked tic ev	10	Joel	Carro1	1	1	Sherry I		Hoag	land
lary	and 2 should t Health and Me tem 27 is mark other traumation		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street ar	nd Number or Ru	ral Route Number		
<u>ა</u>	and 2 Health em 27 ther tr		Jane Hoagland - (			Anchorage	e Way, (	Cean Cit	ty, Maryl	and 21842
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	emetery, crer	sition (Name of natory or other place,		Date	20c. Location - Cit	
Ħ	permit. Pa Departme Importan any injury once,		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licens			y of Delm . Name and Address		-18-201	Delmar, ineral Ho	Delaware
m	permi Depar Impor any ir		Jenis Te	Destarden						yland 21804
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the deat ie cause on each line.	h. Do not ente	r the mode of dying,	such as cardiac	or respiratory arm	est,	Approximate Interval Between
An P	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	Comr	icutors o	of mul	tiple to	rure	Onset and Death
mark 1	Examiner		Todating in doutry	Due to (or as a consequ	uence of):	icutous c				
		iner	Sequentially list conditions, if any, I admit to immediate	<li>Due to (or as a consequ</li>	lence ci):	u apreg i c				
-	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	С.						
_	r requires that the deam certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ia E	resulting in death) Last	Due to (or as a consequ	ience of):					
09/	cate r physi	edical		d						
20	certification and ing use a	N/UE	200. Has acocacht prognant	23c. If yes, outcome of pregna		l e			23d. Date o	f deliverv
Box	dearn of	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of a 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
л Э	at the d by th letach		9 Unknown  Part II. Other significant conditions co		ulting in the u	nderlying cause give	n in Port I	22a Did ta		- t- th
S, F	signe d be c	d b			aning in the G	indonying daddo givo				e to the cause of death?
Vital Records,	v requisions should	Completed						24a. Was a		autopsy findings available
Sec Fee	ate has	آق ا					1	autop perfor 1  Yes	med? prior deat	to completion of cause of h? Yes 2  No
	ertifica ector, p	Be	25. Was case referred to medical examiner?	-		26. Plac	e of Death (Chec	_	2 2 110	ies 2 🗆 NO
<b>-</b>	this c	은	1   Yes 2 □ No  No  No  No	lospital:	ER/Outpatien				ence 6 Other (S	pecify)
DIVISION OT	th. After	Certificate:	1 ☐ Natural 5 ☐ Pending 2 ☑ AccidentInvestigation	28a. Date of injury (Month, Day, Year)	injury	28c. Injury a work? M 1 🗆 Ye	es 2 No		ow injury occurred a St. Peda	estran
IISIC	er deg	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho	me, farm, stre			28f. Location (St	treet and Number or	Rural Route Number,
בֿ בֿ	ral Dil		L	building, etc. (Specify, Coastal HW)	1 OCW				t. oc no	
H	The involved or Authoring Prystolen: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	ledical	(Check 2 Medical Examir	cian: To the best of my knowler: On the basis of examination	and/or invest	gation, in my opinion.	death occurred a	at the time, date an	nd place, and due to	the cause(s) and manner stated
To the	within To the compl	≥	only one 3 l Critiving urse 29b. Signature and title of certifier	Practioner: To the heet of my	- Khawinaga, a	29c. License n			29d. Date signed (M	
			) ( Shu	$\mathcal{L}$		1450	497		11/118	
	20		30. Name and address of person who co							
	State		Chris Shyder, 31. Date filed (Month, Day, Year)	P.O. P.R. M. C. Registrar's Signat	100	E. Carr	oll St.	Salis	bury, m.	D. 21801
	Registra	r	31. Date filed (Month, Day, Year) AUG 18 201	Company of the second	· da	Ke				
			. 251		Market Control					

For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Robert Carruba Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 5157 Bonnie Acres Drive Ellicott City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth **Funeral** (Month, Day, Year, May 8, 19 1 € M 2 □ F Days **Director** 165-24-9279 82 1929 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 28a-f Howard Ellicott City 10e, Street and Number ò 10f. Zip Code Funeral 23a 5157 Bonnie Acres Drive 21043 "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene. Is marked other than "natur raumatic event, the Medical! 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Carruba Concetta Falsetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is Joanne Noelle Carruba/daughter 4805 Bonnie Branch Rd Ellicott City, MD 21043 item 20a. Method of Disposition

20a. Method of Disposition
3 □ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. cemetery, crematory or other place, 4 Donation 5 Other (Specify) Bernard's Cemetery 8/29/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family, F.H. Inc ianita 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SSOPHAGEAL Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): transiland physician ar Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death the g Unknown 9 Unknown P.O. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 24a. Was an page 2 s this certificate has autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director; it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and litle of certifie 29c. License number

State of Maryland / Department of Health and Mental Hygiene.

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28938 2011 8:00 P 4c. County of Death Howard Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1 Tes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian Black, White, etc. White 16b. Kind of Business Industry Nuclear 20c. Location - City or Town, State Hastings, PA Interval Between
Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Month

State Registrar

(Item 23a) (Type, Print)

s Signature

gistra

ne and address of person who completed cause of

Н	Physici /Medic		Howard Leonard Downs		Month Da August 20	2011	9:32 A M
-	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town	n, or Location of Death	40	c. County of Death	
			302:	lendship		Anne Aruno	
	Funeral		Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Year, 08–11–1929	9. Birthpl	lace (State or Foreign try)
	Director		579-36-9749   1A <sup>1</sup> M 2 L F   82 Yrs.   Usual Residence of Decedent		08-11-1929	9   Virg	ınıa
	land ow		10a. State 10b. County 10c. City, Town or Location			1(	Od. Inside City Limits
	Mary -f sh	to	MD Anne Arundel Fri	lendship			1 □Yes 2 💢 No
	r 28a	Director	10e. Street and Number 10f. Zip Cod		10g. C	itizen of What Count	try?
	h with	a D	6524 Wilson Road 207	758		USA	
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Kreen Forces? 13. Was Decedent Kreen Forces?	of Hispanic Origin? (Sp Suban, Mexican, Puerto	pecify Yes or No-	14. Race - America Black, White, e	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show offert Examinat her rotified at	by Fu	1 ☐ Never Married 2 【 Married 1 【 Yes 2 ☐ No		. ,	Specify:	
00	hours tural"	q pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946-86	acumation	16b k	Whi Kind of Business/Ind	
5	in 72	olet	(Specify only highest grade completed) (Give kind of work do	ne during most of work	ing	and or business/ma	ideti y
21215-0036	be filed within 72 ho ital Hygiene. d other than "natu event, fre Medien	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  Commercial S	Sales Repre	sentative	Natural (	Gas Company
	il Hygi other ent, I	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maider		
<u> a</u>		To E	Henry Downs	Delia		M <sup>-</sup>	iddleton
Maryland	short and and and and and and and and and and		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Str	eet and Number or Rui	ral Route Number, City	or Town, State, Zip	Code)
	s 1 and 2 if Health a item 27 is other tra		Dora J. Downs, spouse 6524 Wilson				
ore	of of of		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	place)	Date 20c. L	_ocation - City or To	wn, State
Ë			4☐Donation 5☐Other (Specify) Ft. Lincoln Ceme				
Baltimore,	permit. F Departm Importar any Inju		21. Signature of Funeral Service Licensee		ausch Fune		
	HB = 60		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of		ane, Owings	s, MD 207	36 Approximate
110			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
and a	Physician /Medical		disease or condition resulting in death)	4 2+101	Ce2		
100	Examiner		Due to (or as a consequence of):	tron			
	-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1000			
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	tenu D	15008C		
o,	e exectan an an rial-tr		resulting in death) Last  Due to (or as a consequence of):	1			
68760,	death certificate be executed e attending physician and d for use as the burial-transit	sician/Medical	d				
¥ 68	eath certific attending p for use as t	Mec	IF FEMALE:				
Вох	ath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of delive Month	ery Day Year
0		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specification of the specification of the spe	/)			
٦.	requires that the leen signed by the	Phys	Part II. Other significant canditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
gp	uires 1 sign 1d be	d by	Hypertension		1 ☐ Yes 2	2 XNo 3 □ Prob	ably 4 Unknown
Ö	> 1 70	lete	Hyper lipidemia		24a. Was an	24b. Were auto	psy findings available
Re	e la has	Completed	- 19 pr ripine mas		autopsy performed?	prior to cor	mpletion of cause of
ta	ician: Th certificate ector, pag		25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 ☐N th (Check only one)	lo 1 ☐ Yes	2 □No
of Vital Record		To Be	examiner?	Other: 4 \sum Nursing He		6 ☐ Other (Specify	iv)
0	ding Phys h. After this funeral di	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of logury (Month, Day, Year) Injury	Injury at Work?	28d. Describe how inju		
<u>0</u>	Attending r death. ector: After by the fune	atic	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
Division	or Att after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ce	28f. Location (Street a City or Town, State	ınd Number or Rura te)	I Route Number,
Ω	urs al		<b>X</b>			( )	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in rand phanner stated.				
	To the within 2 To the comple	Me	The Flamer States.	cense number	29d. D	ate signed (Month,	Day, Year)
	1		Han alle	17324	/ %	172/11	
	15 KW		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		, 0	1-11	
_	13 KM		Raymon A. Noble MID 238 Merrimac	34 Prince	ce Fuel.	MD 2	0678
	Sta		31. Date lied (Monta, Day, Year) 32. Registrar's Signature	9			
	Registr	ar	La Markey Sala Markey				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 2011  $A^{\ M}$ 9:32

1 - For State Registrar

11-06364 Kyle M. Doucette

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 1 28940 State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Ce	ertific	ate of	Dea	th			Re	eg. No.			
M = -1" =	Physici		Decedent's Name (First, Middle			_					2	. Date of Deal Month	Day Ye	ar	3. Time of Dear	
ndiC	al Exam	iner	Kyle Marshal  4a. Facility Name (if not institution	Doucette	·		14	h (City)	Town, or Lo		Dooth	August 24	, 2011 4c. County	-f D4	0216 hrs	
			19600 Block Reidtowr	. •	umber)		4		erstown	ocation of	Dealli		Washir		1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birt	hday)		der 1 Year	If Under	24Hrs.	8. Date of Bir		Y) g. Bir	thplace (State or	r _
	Director		213-06-0170	1X M 2 F	30		Yrs.	Mont	ths Days	Hours	Min.		23,1983	Foreig	n Maryla ountry)	and
			Usual Residence of Decedent	1211111 2 1			113.	<u> </u>				PLLE	20,230			
	any		10a. State 10b. County			, Town	or Locatio	on							10d. Inside City	•
	Aaryland 28a-f show 1 at once	<u>ا</u>	Maryland Washir	ngton Cou	nty Hag	gers	town								1 Yes 2	X No
	Aaryla 28a-f 1 at o	Directo	10e. Street and Number		<u> </u>				ip Code			10	0g. Citizen of V	hat Cou	ntry?	
	3a or	Ö	13623 Paradise	Dr.					21742				U.S.A	•		
	death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married		cedent Ever in U	J.S.			lent of Hispa			cify Yes or No-		e - Amer te, etc.	ican Indian, Blac	:k,
	or it	Fur		1 Yes	2 X No				_			. ,		Wh	ite	
	urs afte	þ	3 Widowed 4 Div	or Dates:		16a.			2 X No		ind of wo	rk done	Specify: 16b. Kind of B			
	2 hou	etec	Elementary/Secondary (0-12)		1-4 or 5+)	-	during mo	st of wo	orking life. D							
036	ithin 7 ne. r thar	Completed		4			Stude	ent					Coll	ege		
5-0	Hygie othe	ပိ	17. Father's Name (First, Middle,	, Last)					18	.Mother's	Name (	First, Middle, N	Maiden Surnam	∍)	-	
121	d be fi lental arked	Be	Larry Marshal	Doucette		1.0			C	hris	tina	J. Co	rran Do	ucet	te	
MD 21215-0036	shoul and M 7 is m	To	19a. Informant's Name/Relations		- 11								ber, City or To			
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien and Department of Health and Mental Hygien and Engertains or items 23a or 28a-f she Important: If item 77 is marked other than "natural", or items 23a or 28a-f she Injury or other traumatic event, the Medical Examiner must be notified at once		Christina J. D	oucette-		Place o	ろり <u>とろ</u> of Disposit	Par ion (Na	'AGLSE ame of ceme	Dr.		<u>erstow</u> Date	n, MD 2	<u> </u>	Town, State	
Baltimore,	ges 1 it of H i: If i		1 Burial 2 X Cremation	n 3 Removal f	rom State		ory or other		•		0_26	5-2011	Cmi +h	. h	- MT	
Itim	it. Pa urtmen prtant		4 Donation 5 Other Sp 21. Signature of Funeral Service		ال ال	IIT CI								Fu	neral Ho	
Ba	perm Depa Imp		Kaitin Zald	ann. A	1 15		1.33	1 E2	asterr	n Blv	7d. N	Morth H	lagersto	ับ เพา	MD 2174	12
Pł	nysician		23a. Part I. Enter the disease, or		caused the death	n. Do no									Approximate I	Interval
	Medicid		failure. List only one cause Immediate Cause (Final disease	Marikin Indian	uries										Between Ons Death	
_ =;	kaminer		or condition resulting in death)		a consequence o	of):										
		ايا	Sequentially list conditions,	b.	a consequence of	α£):										
			if any, leading to immediate cause. Enter Underlying Cause	c Due to (or as a	a consequence (	JI ).										
	od sit	Examiner	(Disease of injury that initiated events resulting in death) Last	Due to (or as	consequence of	of):				-						
	te be executed ysician and burial - transit		LINDENDED	d.												
ó	e be e ysicia burial	ğ d	UNPENDED	AMENDED									1001.0.1		<u> </u>	
8760	rtificate ing phy as the t	3	IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg pirth		Feta	al death	3	Ectopic p	pregnand	у	23d. Date of Month		/ Day Ye.	ar
Box 68	attendin for use a	<u> </u>	past 12 months?  1 Yes 2 No 9 Unk	moun	nant at time of de			er (Spe					is .			
Ä.	s that the death cert; gned by the attendir e detached for use a	Physician/Medical	Part II. Other significant conditi	9 Onkn		roo. Itina	n in the un	dorluio	a aauga aiu	on in Bort	1	230 Did to	hacco uso cont	ributa to	the cause of dea	ath?
P.0	that t	b	rat II. Other significant conduc	ions contributing t	o death but not i	resulting	g an une un	deriyiri	g cause give	enmean	, J.				pably 4 Unk	
Ś	law requires to has been signe 2 should be d	Completed by							·			24a. Was a			topsy findings av	
20.0	law re has be 2 sho	휠			<u> </u>							autop	sy		completion of cau	
Re.	certificate ector, page	ខ្ញុ										1 ✔ Yes 2		<b>✓</b> Ye	es 2	No
亞	s certi	a	25. Was case referred to medical examiner?	I In anital.	Inpatient 2	1 50/0	utpatient	2 🗆 (	26.Place of Ot	<u> </u>		<del></del>	Residence 6	Othor	Coope	
₹	ing Phys After thi uneral d	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury		Time of Inj		28c. Injury a				now injury occur		, ocene	
Division of Vital Records,	ath.	릲	1 Natural 5 Pend	ing t	2011 (Par)	0202	hrs		1 Yes	s 2 🗸 N	10 D	river in a si	ingle vehicle	roll o	ver	
/isi	r Atto ter de: irecto n by t	fig		stigation 28e. Plac	e of Injury - At h	lome, fa	rm, street	, factory	y, office buil	ding, etc.					ral Route Numbe	er, City
ă	Hospital or Attending Physician: The law requires that the death certificate be executed burns after death.  Funeral Direct After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	outdide		Local Stre	et					19	or Town, Si 600 Block R	tate) Reidtown Roa	d, Hage	rstown, MD	
			Tonioni only	nysician: To the be	-	-										
	To the Hos within 24 h To the Fun completely	Medical		miner:On the basis and manner s		and/or ir	rvestigatio				urred at ti	ne time, date a				
		Σ	29b. Signature and title of certifie	er .	1			29	c, License r						nth, Day, Year)	
			tamen for	thall m	0				O.C.M.	E.			August 24	, 2011		
la 1	0		30. Name and address of person Pamela E. Southall, M		se of death (Iten Medical Exa		900	\/\ D	altimore 9	Street	Raltim	ore, MD 21	1223			
W	_		31. Date filed (Month, Day Year)		gistrar's Signat		300	vv. D		oneet,	Daillilli	JIE, WID 21				
	S	tate	The Batte mod (Worth, Day	9794	-grandra orginali	al de	-	0 6	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie Genevieve Deal <u>2</u>01 1 August 2:28 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6109 Addison Road Seat Pleasant Prince George's Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 88 Months Days Hours Min petroit, Mich. Director 219-10-6868 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Md. Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6109 Addison Road 20743 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clinical Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Moses Wilkinson Annie Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6109 Addison Road, Seat Pleasant, Maryland 20743 Wyatt D. Deal/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 08/30/11 Landover, Maryland 4 Donation 5 Other (Specify) Harmony Mem. Park 21. Signature of Funeral Service Licenses P. Name and Address of Facility Henry S. Washington & Sons Co., Inc. ar 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Poorly Differentiations disease or condition Medical resulting in death) **Examiner** Adenocarcinoma-Unknown Primary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Metastatic Cancer to Liver Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🐼 No
9 ☐ Unknown Month Year Pregnant at time of death Day certificate has been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 4 ☐ Nursing Home 5 🗃 Residence 6 ☐ Other (Specify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours a er deeth.

eral Director After this certific filled in by the funeral director, 24 hours

1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 XNatural 5 Pending Accident Investigation

28d. Describe how injury occurred work?
1 Yes 2 🗆 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one 29b. Signature

1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

08/23/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anita Clayton, M.D. 1221 Mercantile Lane, Upper Marlboro, Maryland 20774-5374

D0057402

State Registrar

Medical

Could not be

determined

Suiciae
Homicide Suicide

within 24 hor To the Fune completed fi

DURHAM, MARCUS

					ase Type										-	ible.		
			1 - For American	nd Ite	m 5 Sta	te of M	922,1	2/15/2 Cer	tificat	nt of F te of C	lealth Death	and N	1ental Hy	/giene Reg. <b>N</b> e	e 201		289	342
	Physicia		1. Decedent's Name Marcus	(First, Middle	. ,	ırham							2. Date of De Month	eath		Year //		of Death <b>25р</b> м
	Medic Examir		4a. Facility Name (if n	ot institution	, give street an						Location	of Death	Taga	40	. County	of Death		
700	Funeral		Doctors F. Social Security Nur. 216-35-84		6. Sex		je (In yrs. la	st birthday)	If Unde	nham er 1 Year	If Under		8. Date of Bir	rth	T		orge '	S or Foreign
	Director		577 23 24 Usual Residence of D	04_	1 🕱 M 2 [	F 2	.5	Yrs.	Months	Days	Hours	Min.	08/30/	1985		Cour	D D	
	yiand -f show ed at	ctor	10a. State	10b. County	- Cooms	! .	′	, Town or Loc	ation							1	0d. Inside	-
:	or 28a	Director	MD  10e. Street and Numb		e Georg		Bow		10f. Zi	p Code				10a. Ci	itizen of W	/hat Cour		es 2 🗆 No
	n with	Funeral	10213 Sea	Pine	s Drive	2			20	721				_	ted		•	
036	perim. Tage I and 2 should be littled within 72 hours sher death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☑ Never Married 3 ☐ Widowed 4		ried Arm	Decedent ed Forces? Yes 2 🔀 es, Give or Dates.		If	Yes, spe	cify Cuba	spanic Ori n, Mexicar Specify.	n, Puerto	cify Yes or No- Rican, etc.)	-		k, White,	an Indian, etc. ack	
15-0	"natu	Completed	(Speci	15. Deceder ify only highe	nt's Education est grade comp	leted)		16a. Deced	ind of wo	rk done d	ation uring mos	t of worki	ng	16b. k	(ind of Bu	siness In	dustry	
21215-0036	giene.		Elementary/Secon	nday (0-12)	Colle 2+	ege (1-4 or s	5+)	Hote!		e retired) nager	•			Pri	vate			
and,	ntal Hy ed oth event	To Be	17. Father's Name (Fin		.ast)								(First, Middle,	, Maiden	Surname,	)		
aryl	snould be me and Mental I 7 is marked o raumatic eve	ľ	Smith Du 19a. Informant's Nam	-	nip (Type, Print)	)		19b. Mailin	a Addres	s (Street a		ma Di	l Route Numbe	er City o	r Town St	ate Zin (	Code)	
Z ·	lealth a m 27 is ner tra		Wilma Elbo		i /Moth	ner			-				Bowie					
Baltimore, Maryland	age la	1	20a. Method of Dispo	Cremation	3 🗌 Remova	from State	Nati	ace of Dispos <b>Tona 1</b> 'en	Havin	ther place	9)	0.404	oate 9/2011	1		-	own, State ary1a	nd
altir	Departme Importan any injur		4 Donation 5	_			Memo	orial 1					e Fune					.IIu
<u> </u>			Taut o		of MC			553	38 Ma	ar1bo	ro P	ike,	Forest	vil1				
P	iysician/	8 3	23a. Part 1. Enter the shock, or heart t Immediate Cause (Fin disease or condition	failur <b>è</b> . List o	nly one cause	on each line	the death	. Do not ente	r the mod	ne of dyling	, such as	cardiac o	r respiratory ar	rrest,		ļ	Approxim Interval B Onset and	etween
	Medical xaminer		resulting in death)	9	a. Du	ue to (or as	a conseque	ence of):								_		
1		iner	Sequentially list cond if any, leading to imm	nediate 🔝	b. —	ue to (or as	a conseque	ence of):										
patricaxa	ian and irial-transit	Examiner	cause. Enter Underly Cause (Disease Or interthat initiated events resulting in death) La	jta y	c	ue to (or as	a conseque	ance off:								-1		
			rodaling in doubly La		L d	10 10 (01 00	a conseque											
6876 ertificat	ding ph se as th	/Mec	IF FEMALE:		23c If ye	s, outcome	of pregnan	ICV.										
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death cartificate ha	been signed by the attending physic should be detached for use as the b.	Physician/Medical	23b. Was decedent print the past 12 module 1 Yes 2 Unknown	onths?	1 4	Live Birth Pregnant a Unknown	2 🗌 Fetal	death 3 [	Ectopic Other (s)		′				23d. Date Mor		ery Day	Year
Division of Vital Records, P.O. talor Attending Physician: The law requires that the	en signed l	þ	Part II. Other signification		<u> </u>								1 🗆				ne cause of pably 4	death?
e law re	2 33	Completed	ACQUI	RED				ICEN	164	SY	NOB	LUMF	dato	psy	, pi		osy findings mpletion of	
<b>al Re</b>	tificate tor, pag	Be Co	THROM 25. Was case re erred		TOPE	NIA				26 Pla	ce of Deat	th (Check	1 🗆 Yes	2 No		Yes	2 No	
F Vita	this cer al direc	입	examiner? 1  Yes 2	No				R/Outpatient	3 🗆 D	100	r.		ne 5 🗆 Resid	dence 6	i ☐ Other	(Specify	)	
ono Idina F	ath. : After e funer	cate	27. Manner of Death  1 Natural 2 Accident	5 Pendin	g	Date of inju (Month, Day	ry (, Year)	28b. Time of injury	M 2	8c. Injury! work?		- 1	8d. Describe h	now injur	y occurre	d		
Division Atte	within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page	l Certificate:		6 Could r determi	not be 28e. I	Place of Inju ouilding, etc		ne, farm, stree	et, factor	, office		2	28f. Location (\$ City or Tow			or Rural	Route Nun	nber,
Hospi	24 hour Funera	Medical	(Check 2 L	Medical E	Physician: To xaminer: On th	ie basis of e	xamination :	and/or investi	gation, in	my opinior	ı, death oc	curred at	the time, date a	and place	, and due	to the cau	ıse(s) and m	nanner stated
Tothe	within <b>То the</b> сотр		only one) 3 ∟ 29b. Signature and titl		Nurse Practic	oner: 10 the	best of my i	Knowledge, de		red at the License		and place	e, and due to th		s) and mar te signed			
	5			W			n #:			Da	15	55.	2	0	8-5	5-	1 (	
	41		30. Name and address	ERI	FAN	8 II	8 G	00 d	Luce	KR	OAG	L	ANHAI	Λ,	MD	20	706	
	Stat Registra	e ir	31. Date filed (Month, I	9 2011	Same	32. Registra						7		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28943 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ INO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 199 Garden Gate Lane Annapolis <u>Anne Arundel</u> Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕻 Days Hours Min July 3 1938 216-34-8561 73 Maryland **Director** Yrs Usual Residence of Decedent or 28a-f show notified at 10a, State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel 1 ☐ Yes 2 🔀 No Annapolis 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 199 Garden Gate Lane 21403 USA items 2 "natural", or item ledical Examiner וי 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Jed with all Hygiene.
Jed other the cevent, the Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Teachers Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever မ Page 1 and 2 should be ment of Health and Ments Moses J. Booth Reba Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other t Clinton S. Davis (Husband) 199 Garden Gate Lane Annapolis, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veteran 8-29-11 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. Signature of Funeral Service Licenses Winniame Receive of & Cilisons Mortuary, P.A. 1922 Forest Dr. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Poset and Depth 5 Physician | disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence oi). if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: IF FEMALE.
23b. Was decedent pregnant
in the past 12 morths? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month 1 Yes 2 No 1 Live Birth
4 Pregnant
9 Unknown Dav Year Pregnant at time of death 9 🗌 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 📈 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 6 Other (Specify) 27. Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 8 8 30. Name and address of person who co pleted cause of death (Item 23a) (Typ IGHTFUOT-IAYLOR 31. Date filed (Month, Day, Year) State AUG 2 4 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dixon Marie Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗐 F Months 100° 90 Director 200-28-4100 74 7936 Usual Residence of Decedent 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Cumberland Allegany 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or Funeral 1411 Frederick Street 21502 USA er than "natural", or items the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 🗆 Yes 2 🗖 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) own home homemaker event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Elizabeth Sutton Clement Tomlinson Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) George Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Crem**a**tion 3 ☐ Removal from State Sunset Memorial Park Cumberland MD tion 5 C Other (Specify) Don permit. 22. Name ar Scarpellif Fuitieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the burial-transi Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death signed by the and be detached for Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed death? ☐ Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗀 Yes 2 🖪 No Other: ျ 1 Inpatient 2 Z ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one Certifying Nurse Practioner: To the best of my knowledge, death occ urred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature/ and title of certifie 29d. Date signed (Month, Day,

Registrar

State

200 GLENN ST. STE 302 CLUMBERLAND, IND 2156

use of death (Item 23a) (Tee, Print)

J.BARRÉRAJR MO.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5 per fth 9919 9-9-11 Hsm that Mental Hygiene Certificate of Death Reg. Nø. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Edith Decker Menth 08 2011 0300 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hidden Treasures Assisted Living Westminster Carroll . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth 1 M 2 X Days Hours 88 0270171923 Director 217-48-4653 Usual Residence of Decedent or items 23a or 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 564 Marshall Drive 21157 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3X Widowed 4 ☐ Divorced Specify: White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) . Page 1 and 2 should be filed within ment of Health and Mental Hygiene. College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 James Freeland Ida M. Badders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r Roy McMillan, son 2928 Cedarhurst Avenue, Finksburg, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 21048 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Carroll Cremation 09/02/2011 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel Sighanre of Funeral Service Licer 412 Washington Road, Westminster, MD 21157 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CANTASO disease or condition resulting in death) ) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2No 유 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 10 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral E 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner the best of m ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cept D37949 (Item 23a) (Type, Print) eles mags Date filed (Month, Day, State FP 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06410 Steven Drendel State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Month Medical Examiner 1916 hrs August 25, 2011 Steven Drendel 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 26 Cambridge Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 647-18-0946 Country) 1 x M 2 F 17 10/3/1993 UT Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 X No MD Ceci1 E1kton hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 靣 26 Cambridge Road USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 5 If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: White Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. 12 College Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert S. Drendel Susan K. Taylor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages I and 2 shoul ment of Health and M tant: If item 27 is m or other traumatic. Albert S. Drendel - father 26 Cambridge Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 09/01/2011 mportant: 4 Donation 5 Other Specify T. Foard Funeral HOme Rising Sun, MD è 21. Signature of Funeral Section 22. Name and Address of Facility R.T. Foard Funeral Home, PA Main Street, Elkton, MD 2192 Approximate Interval Part J Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he **Physician** failure. List only one cause on each line. Retween Onset and /Madina Death a Intraoral Shotgun Wound Immediate Cause (Final Asease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo signed by the detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 2 No 28a. Date of Injury FOUND: Day, Year) After 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Subject shot self 1 Natural FOUND: Pending 1 Yes 2 V No the To the Funeral Director: Aug 25, 2011 1900 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Y Suicide 6 Could not be or Town, State) 26 Cambridge Road, Elkton, MD (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ga 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (Sues o O.C.M.E August 27, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31 Date fled Go3h Ca 2014 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Month Physician/ 0 XOY oan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** <sup>Year)</sup>9<u>33</u> 1 🗆 M 2 🔀 F July 24, Director 288-30-3761 78 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location Director Ellicott City MD Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 er than "natural", or items 23a or the Medical Examiner must be Funeral 21043 United States 2617 Orchard Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Midowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ Wilkes Viola Harold Fredericks traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code + Health a 127 Newburg Avenue Catonsville, Maryland 21228 Scott Dixon/son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Good Shepherd Cemetery 8/25/2011 Ellicott City, MD 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 anute 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ohysician and the burial-transit that the death certificate be executed resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 9 Unknown 9 Unknown P.0. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? Yes 2 No Hospital or Attending Physician: The I
 hours after death.
 Funeral Director: After this certificate h 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Division of Vital Hospital: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 10 CHARTER DRIVE Day ran 31. Date filed (Month Day Ye Registrar's Signature 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011

00:45 AM

9. Birthplace (State or Foreign Country) New York

White

10d. Inside City Limits

Onset and Death

Month

Day

Year

1 🗆 Yes 2 🎦 No

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Boatwright Frances Dawson August :58P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico Funeral Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Min 253-34-4530 Hours 09/26/1918 Alabama Director 92 Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ortant; If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 1109 S. Schumaker Drive 21804 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Domestic Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Haire Thomas B. Boatwright Marion and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Camden Ave., Salisbury, MD 21801 permit. Page 1 and 2 st Department of Health a Important: If item 27 is Marion Robinette/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burjal 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory or other place) 8/16/2011 Salisbury, MD 4 Donation 5 Other (Special) 21. Signature of Fu eral Service <sup>22</sup>HOIIOway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 art 1. Inter the disease, or complications the caused shock, or heart failure. List only one cause of each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between me Jate Cause (Final discose or condition sulting in death) Onset and Death Fhysician, Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: Was deceded in the past 12 month Ves 2 No 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Pregnant at time of death Unknown ate has been signed by the a page 2 should be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? eral Director; After this certificate I filled in by the funeral director, pag 1 Yes 2 No 2 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Dea (Check only one) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (018 Thimmarayappa M.D. <u>Mahesha</u> 910 Easternshore Dr Salisbury MD 21804

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28949 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Month Winifred Ε. Exeter August 9:30 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Morning Star Ass't Living Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral 1 □ M 2**X** F Days (Month, Day, Year, 6-19-1924 Hours Min Georgetown, GUYANA Director 578-94-3600 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Funeral Director MD Prince George's Glenarden 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7922 Echols Ave 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. Black Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Certified Nursing Ass't Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred Collins Anna Rosina Pyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Somir ( Daughter) 7922 Echols Ave. Glenarden, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 8/27/2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Kuhrt hory II 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ enebral Intanction with disease or condition resulting in death) Medical **Examiner** ARTERIOSCHURCHE Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): D. Sease To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ aphasia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📝 Unknown Dysphapia 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 \( \text{Yes} 2 🔲 No within 24 hours after death

To the Funeral Director: 

completed filled in by the f Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) G-5-55 19 2011

State Registrar 42051

vecashore Rel Hentsville Min 2015,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOLE

DE

31. Date filed (Month, Day, Year

AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me, g919 9-16-11 sm. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 10, 2011 Year Margaret Catherine Ellis 8:28  $P_{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 F Days Hours Months March 25,1943 Washington, DC Min. Director 577-56-9973 68 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho; any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Prince George's Morningside 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6811 Pickett Drive 20746 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify:White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Company Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Charles Ena Galaeno Piazza Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen W. Ellis - Husband 6811 Pickett Dr., Morningside, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place)
4 Donation 5 State Other (Specify) Entombment Resurrection Cemetery 8/15/2011 Clinton, MD of Funeral Service Ligenses 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ARDIOGENIC Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Cagu Gause (Disease or linjury Examiner physician and the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a d be detached f 1 Yes 2 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by WRONARY ARTERY disense, POST OPERATIVE bleeding 1 Yes 2 No 3 Probably 4 Unknown DIA-bettes TYPE two HYPERTENSIVE dISEASE OBESITY 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has ours after death.

eral Director. After this certificate I filled in by the fune al director, page perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital 2 X/110 Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) 1. Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number eted cause of death (Item 23a) (Type, Print) -IVINGSTON

State

Registrar

AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28951 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23:03 M Marion Phillip Eldridge 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth

Physician/ Medical **Examiner** 

For State Registrar

	Director	ı	213-70-9	811	1 <b>½</b> M 2 □ F	58		rs. Months Days	Hours	Min. 1	(Month, De	y, Year) 195		Sintippiace (State o Country) Innsvlvar	
	we		Usual Residence of								21271	175	- 110	тпгэйтлаг	ца
	yland f shc	횭	10a. State MD	10b. County	George's	10c. City	Town	or Location	l					10d. Inside C	,
	Mar 28a- notifii	Director			George s			Blade	nsbui	rg				1 🔀 Yes	2 🗌 No
	with the s 23a or ust be r	Funeral D	10e. Street and Nun 5715 En	<sup>nber</sup> Nerson S	treet			10f. Zip Code	20710	)		10g. C	itizen of What USA	Country?	
36	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1  Never Marri		12. Was Decedent Armed Forces? 1 ☐ Yes 2X If Yes, Give			13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexica	an, Puerto Ric	Yes or No- an, etc.)		Black, W	merican Indian, nite, etc.	
8	tural al Ex	ted	3 Widowed		Year or Dates.			T LI Tes 2 LX NO	Specif	у.			Specify:	Black	
Maryland 21215-0036	within 72 ho giene. er than "na f, the Medic	Completed by	Elementary/Seco	onday (0-12)	grade completed)  College (1-4 or	5+)	(	Decedent's Usual Occup Give kind of work done of ife. DO NOT use retired)	during mo	ost of working		16b.	Kind of Busine		
2	filed wit al Hygie d other event, th	Be C	12t 17. Father's Name (f		*)			Custodia					Priva	te	
ano	uld be file Mental I narked o natic eve	10		m Ampie	u)				18. Mot	ther's Name (Fi			,		
2	should be file and Mental I 7 is marked c raumatic eve		19a. Informant's Na		(Time Print)		401						pencer		
Ma	2 shou Ith and 27 is m traum	- 8		Eldrid				Mailing Address (Street a							
σĵ	and Hea		20a. Method of Disp		(5011)	20h Pi		Disposition (Name of	DUL	Date				or Town, State	
D 0	age 1 ent of t: If i				Removal from State	, ce	metery,	crematory or other place od Cemetery		8/27/2			•		
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of	- 3	2(1. Signation	5 Other (Spe		GIE	STIWC	22. Name and Addres					shingto		7
B	permi Depar Impor any ir		Mate	100	alimon	2)		2818 E. Ba	altin	ore St	reet.	Ba]	timore	MD 2122	4
	Ph sician/		shock, or hear Immediate Cause (F	t failure. List only Final	one cause on each line	e.		t enter the mode of dying	g, such a	s cardiac or re	spiratory ar	rest,		Approximat Interval Bet Onset and	e ween
	Medical		disease or condition resulting in death)	n 🚜	a. The Due to (or as				ne	vien	Mr	Ne	ge		
	Examiner				Huse	ten	SUR	م					0		
	ű.	iner	Sequentially list cor if any, leading to im cause. Enter Under	nditions, mediate	b. Due to or as	a conseque	nce of)	:							
	uted d ansit	ami	Cause (Disease or in that initiated events	injury										ļ	
	exec an an rial-tr	Ě	resulting in death) L	ast	Due to (or as	a conseque	nce of)	:							
90	te be nysicii ne bu	dica		•	<b>d</b>										
87	tifical ng ph as th	Me	IF FEMALE:										-		-
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical Examiner	23b. Was decedent print the past 12 mm 1 Yes 2 19 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death	3  Ectopic pregnanc 5 Other (specify)	У				23d. Date of o	-	Year
O.	hat thed by	y P	Part II. Other signifi	cant conditions	contributing to death b	out not resul	ting in	the underlying cause giv	en in Par	t I.	23e. Did to	obacco	use contribute	to the cause of d	eath?
ords, F	requires that the de been signed by the should be detached	eted b									1 🗆	Yes 2	□ No 3 □	Probably 4 💢	Unknown
Reco	<b>Physician:</b> The law r this certificate has b ral director, page 2 sl	Completed									24a. Was autor perfo	osv	prior t	autopsy findings a o completion of c ? 'es 2 🗌 No	available ause of
E.	cian: ertific ector,	Be	25. Was case referre examiner?	d to medical				26. Pla	ace of De	ath (Check onl					
Ś	hysik this o	မ	1 🗆 Yes 2 🔀	No				oatient 3 DCA Othe	er: 4 🗆 N	Nursing Home	5 🗆 Resid	dence	6 ☐ Other (Sp	ecify)	
Division of Vital Rec	ttending P death. ctor: After t y the funers	Certificate:	27. Manner of Death  1 Natural 2 Accident	5 Pending		ry v, Year) 2	8b. Tin inju	ury work	rat ? Yes 2 □		Describe h	iow inju	ry occurred		
Divisi	tal or Attend rs after death al Director: /		3 ☐ Suicide 4 ☐ Homicide	6 U Could not determine			ie, farm	n, street, factory, office		28f.	Location (S City or Tow			Rural Route Numb	per,
	To the Hospital or within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2') only one) 3		<b>niner:</b> On the basis of e	xamination a	and/or i	eath occured at the time, nvestigation, in my opinio lge, death occurred at the	n, death c	occurred at the	time, date a	nd place	e, and due to th	e cause(s) and ma	nner stated
	vitl To		29b. Signature and ti	tle of certifier	brook	esi	MC	29c. License		83		29d. Da	ate signed (Mo	nth, Day, Year)	
>	2			ss of person who	completed cause of d						 0785	,			

State Registrar 31. Date filed (Month, Day, Year) AUG 2 4 2011

State of Maryland / Department of Health and Mental Hygien 20

28952

	ı	Ī
	1	
ysician		
Medical		
	١.	

For

Physician
/Medical
Examiner

**Funera** Directo

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi. Division or Vital Records, P.O. Box 68760,

Regist

	Registrar			$C\epsilon$	rtifica	te of l	Death	7		Reg. No	0.			
	1. Decedent's Name (First, Middle	e, Last)							2. Date of De			V	3. Time of Death	
ian	Wil-	lie Beatr:	ice Frid	av					Month August	- 14		Year <b>1</b>	1:30 A N	Л
ical	4a. Facility Name (If not institution			ау	4h City	, Town, or	r Location	of Death	214gub t		c. County or		11.30 21	
ner														
	Manor Care 5. Social Security Number			l= = 4 l= l=4b=d= .	) If I Inde	er 1 Year	vy Ch	r 24 Hrs.	0 Date of Dir	rt la		tgom		
		6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. i	as <i>t birtrid</i> ay Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Feb. 1	ay, Year	1025	э. ынпр <i>Сои</i> р	olace (State or Foreig otry) rginia	רון
	231-44-7607		76	113.					reb. 1	4,	1935	V I	rginia	
7	Usual Residence of Decedent		10.00											
	10a. State 10b. County		10c. City	, Town or L	ocation							1	0d. Inside City Limits	
용	DC							Wasl	hington	L			1 X Yes 2 No	3
Funeral Director	10e. Street and Number				10f. Z	ip Code				10g. C	itizen of Wh	hat Cour	ntry?	
	1000 Kenilwor	th Arronno	NE				2001	q		T	Jnited	1 5+	atec	
era	11. Marital Status		cedent Ever in U.	S 13	Was Dec				ecify Yes or No				an Indian,	_
ļ <u>.</u> 5	1 ☐ Never Married 2 🖪 Marr	Armed F	orces? 2 XNo		If Yes, sp	ecify Cuba	an, Mexica	an, Puèrto	ecify Yes or No Rican, etc.)	Ĭ		, White,		
<u>&gt;</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive		1 🗆 Yes	2 <b>⊠</b> No	Specify	y:			Specify:			
Completed by		The second second	Jates.	40. D		-10	-11			1 405 1		meri		_
ete	15. Deceden (Specify only highe	t's Education st grade completed,	,	(Giv	edent's Us e kind of w	ork done o	durina mo	st of work	ting	16b. i	Kind of Bus	iness/in	dustry	
臣	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT		•							
Ö		5+		Tea	cher	<b>–</b> Но	me E	conon	nics		Gove	rnme	ent	_
Be (	17. Father's Name (First, Middle,	Last)					18. Moth	ner's Name	e (First, Middle	, Maide	n Surname	)		
10 E	L	oyd Burre	11					F	Beatric	e Sm	ni th			
-	19a. Informant's Name/Relations			19b. Mai	ing Addres	s (Street	and Numi		ral Route Numb			State, Zip	Code)	
	Erodoriok Erid	ov - Unah	and	1000	Keni	Ilron	+h ^;		NE LI	aahi	ngton	D.	20019	
12 3	Frederick Frid 20a. Method of Disposition	ay - nusb		lace of Disp			UII A		Date We		ocation - C			
	1 ☑ Burial 2 ☐ Cremation	3 □Removal from	State Cro	emetery, ch	ematory or	other place	e)		st 26,	200.1		Jily Of To	own, otato	
	4 □ Donation 5 □ Other (S	Specify)	C.C.	Churc	ch Ce	meter	·y	20:	11				irginia	
	21. Signature of Funeral Service	License	1	, Q i	22. Name a	and Addres	ss of Faci	ility Ste	wart F	uner	al Ho	me,	Inc.	
9	Man To	Ter	valt-	7	001 I						ton,		20019	
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death								, com,		Approximate	
		only one cause on	each line.									Ų	Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)	aOv	arian Ca	ncer										
	resulting ar death)	Due to	(or as a consequ	uence of):										
	Sequentially list conditions	b												
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	uence of):										
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events													
Examiner	resulting in death) Last	Due to	(or as a consequ	uence of):										
8		C <sub>d</sub>												
/Medical		u.												
Me	IF FEMALE:	23c If yes ou	utcome pf pregna	ncv							Ood Date	بداماماند		
ä	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 Feta	death 3	Ectopic		/				23d. Date Mon		Day Year	
sic	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	9□Unki	nant at time of do	eath 5	Other (	specity) <u> </u>								
Physicia														
by	Part II. Other significant conditi	ons contributing to	death but not resu	alting in the	underlying	cause give	en in Part	t I.	23e. Did	tobacco	use contril	bute to t	he cause of death?	
pe	Breast Cancer								1 🗆	Yes :	2 🔀 No 🤅	3 ☐ Prob	bably 4 □Unknow	/n
Completed									24a. Was	an	24b. W	/ere auto	opsv findings availab	le
E									auto	opsy ormed?	pr	rior to co eath?	ppsy findings availab impletion of cause of	
	ar w								1□ Yes	2 🔼 N	lo 1	□Yes	2 No	_
Be	25. Was case referred to medica examiner?							ce of Deat	th (Check only	one)				
은	1 Yes 2 No			ER/Outpatie			4 124 1	Nursing Ho	ome 5 Res				fy)	
	27. Manner of Death 1 X Natural 5 ☐ Pendir	28a. Date (Mo.	e of Injury nth, Day Year)	28b. Time Injury	of	28c. Injur Worl	y at k?		28d. Describe	how inj	ury occurre	ed		
atic	2 ☐ Accident investi	gation			M		Yes 2	□No						
iţi	3 Suicide 6 Could 4 Homicide determ	sined   28e. Plac	e of injury - At ho	me, farm, s	treet, facto	ry, office			28f. Location	(Street a	and Numbe	r or Run	al Route Number,	
ert	4 🗆 Homicide	Duik	ding, etc. (Specify	()					City or To	owii, Sia	ue)			
C	29a. Certifier 1 X Certifyii	ng Physician: To th	e best of my kno	wledge, dea	th occurre	d at the tir	me, date a	and place	and due to the	e cause/	(s) and mar	nner as s	stated.	_
Medical Certification:		Examiner: On the												
Mec	29b. Signature and title of certifie		unusudi	-	2	9c. Licens	e number			29d D	ate signed	(Month	Day, Year)	
	1. 4	Austo 1	$\gamma \cap$											
	Jumme	0 10 0) 1	" "			D006	8890			Aug	gust :	18,	2011	
	30. Name and address of person	who completed cau	se of death (Item	23a) (Type	, Print)									
	299 Harley Ave		ville, I		and	20851		Summ	it Gupt	a				
ate	31. Date filed (Month, Day, Year)		Registrar's Signa											_
rar	AUG 2 2 2011	Maria .	A. 100	color										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ Year 2011 <u>4:05a<sup>M</sup></u> Joseph Ashby Faxio Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Fort Washington 2710 Gable Court Prince Georges Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Days 1 🖾 M 2 🗆 F Hours Min. Month, Day, <sup>Ye</sup> 1947 578-58-3929 64 Yrs Director Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗓 Yes 2 🗌 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 522 46th Street SE 20019 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed 3 - Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Self Employed Vendor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Mark Faxio Lily Florence Chappell Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 13900 Floyd Street Upper Marlboro MD. 20772 Reneen Johnson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗎 Removal from State Harmony Memorial Landover, Maryland 4 Donati 5 Other (Specify) 8-26-2011 uneral Service Licer 22. Name and Address of Facility John T. Rhines Funeral Home Si ture 3005 12th Street NE Washington DC 20017 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate pock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a cossequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year the a 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 No Probably 4 Unknown Records, icate has been sig r, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 1 🗆 Yes 2 🏝 No certificate director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Friends Residence 2 3 No Hospital: မ 4 Nursing Home 5 Residence 6 D Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral to 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖾 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2011

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ivan Zama, MD 9200 Suite 200 Largo Maryland 20774

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28954 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 20 Day 2011 Year Physician/ Virginia Belle Hilten Favreault 7:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Edenton Retirement Community Frederick If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Davs Hours Min. . 191<u>3</u> 97 Nebraska 579-09-57 Director Nov. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director Maryland Frederick 1 Yes 2X No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 5911 Genesis Lane 21703 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ŏ ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes, Give "natural", Completed 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry United States General Accounting and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Clerk Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည William Hilten Susie Spence 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8159 Bozman Neavitt Rd. Bozman, MD 21612 Brenda Seek / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 22, cemetery, crematory or other place)

Resthaven Crematory 1 Burial 2 XX Cremation 3 Removal from State 4 ☐ Donation 5 Other (Specify) 2011 Frederick, Maryland 21. Signature of a neral Service Line see Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ₽nysician/ ementi a Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Examin and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? this certificate has ral director, page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မ ALF 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify nin 24 hours after death.

the Funeral Director: After thi

pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2.

To the F

complet only one 29b. Signatura and title of certifier 29d Date signed (Month, Day, Year)

3

State Registrar ate filed (Monit) Day, Year) 2011 32, fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ture barre

41702

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.
Amend 29d per med cert G919 9/15/11 dk
State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 08 10:00 PM Eula M. Fuller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Ceci] Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8 Date of Birth **Funeral** Days Hours Min Month, Day, Year) 03/19/1919 1 ☐ M 2 😿 F Director 218-22-1168 83 VA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo MD Port Deposit Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>48 Maple Hill Drive</u> 21904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 x No Specify. White Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Honaker Otis Honaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Oak Court Port Deposit, MD 21904 Phyllis Pennington - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗔 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hopewell Cemetery 08/31/2011 | Port Deposit, MD Signature of Funeral Service 22. Name and Address of Facility R.T. Foard Funeral Home, PA Queen Street, Rising Sun, MD 21911 S. 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death STAGE DENENDA Physician/ disease or condition Medical resulting in death) Examiner PULMONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performer prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes 1 Minpatient 2 ER/Outpatient 3 DOA ၉ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending (Month, Day, Year, injury work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe P.V Noy August 29, 2011 DEO 657 35 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) RAS , 126 A E. MGH I MUST NARTHANA ISLK PU MD UGL!

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year A M 0339 Thomas 2011 Medical ugus+ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Tennessee 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 1 F Days Min. Hours 03/28/1940 215-36-4175 71 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Maryland Anne Arundel Edgewater 1 Tes 2 No ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with 3682 8th Ave Apt.A 21037 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ٩, 1 □XYes 2 □ No If Yes, Give Year or Dates. 62–66 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural" 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event than "na (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) printer printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Louise Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Green, Jr. - son 39790 Combs Rd. Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition 20c. Location - City or Town, State Metropolitan Funeral Service 08/24/2011 1 Burial 2 XCremation 3 Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service License 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Non-ST elevation infarction myocardial Medical resulting in death) **Examiner** Right - sided Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner to (or as a consequence of, physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ellulitis Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 nding p IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 □ No Other: 은 1X Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 🗆 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100484 August 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Rebecco E. Duncan, MD

31. Date filed (Month, Day, Year)

AUG 2 4 2011

South Greene

Baltimore,

Street

22

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

zneryi Gaugna	''	1- For State Registrar	tate of Marylar	•	artment o <i>rtificate o</i>		Mental F	, ,	Reg. No. 2011	28957
Physic Medical Exam		1. Decedent's Name (First, Midd	dle,Last) Cheryl	Dian	Gaughan		-	2. Date of Dea	ath Day Year	3. Time of Death
Medical Exam	IIIGI	Cheryl Diane  4a. Facility Name (if not instituti		ber)	т	4b. City, Town, or L	ocation of Dea	Septembe	er 1, 2011	0916 hrs
		Meritus Medical Cent	· -			Hagerstown			Washington	
Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24H		rth(MM/DD/YYYY) 9. B	ign
Director		213-68-6058	1 M 2 X F		61 Yrs		Hours Mi		22,1950 °C	ountry) Maryland
AOY		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Locat	ion				10d. Inside City Limits
and show	<u>ا</u>	Maryland Wash:	ington	Ha	gerstow	m				1 Yes 2 X No
Maryland 28a-f sho	Director	10e. Street and Number				10f. Zip Code	<del></del>	1	10g. Citizen of What Cou	untry?
with the Maryland ns 23a or 28a-f sho be notified at ooce		12213 Bucky Av				21740			USA	
death wi	Funeral	11. Marital Status 1 Never Married 2 M		es?		as Decedent of Hisp es, specify Cuban,			o- 14. Race - Ame White, etc.	rican Indian, Black,
after d	by F.		or Dates:	2 X No	1	Yes 2X No	specify:		Specify: Wh	ite
hours natur Exami	ed t	15. Decedent's Education (Spe	ecify only highest grade			nt's Usual Occupationst of working life. I			16b. Kind of Business	/Industry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		ic Artist		,	Federal (	Government
5-00 led wit tygien other	Con	17. Father's Name (First, Middle			-			ne (First, Middle, I	Maiden Surname)	30 V CETAMOTTO
21215-0036 21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic evect, the Medica	Be C	James Emanuel 19a. Informant's Name/Relations						melia Ca		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene. n 27 is marked other than "natural", or Items 23a or 28a-f she numatic eveot, the Medical Examiner must be notified at ooce	ဥ	Nicholas H. Ga		n		chokeberr			mber, City or Town, State burg, FL 320	
e, N I and Health Fitem		20a. Method of Disposition		20b. I		ition (Name of ceme		Date	20c. Location - City o	
imore, MD 2121 Pages I and 2 should be fi ment of Heatth and Mental lant: If iten 27 is marked or other traumatic eveot,		1 Burial 2 X Cremation 4 Donation 5 Other S			-	n Cremato	ry 09-	-04-2011	Hagerstown	.Marvland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		21. Signature Funeral Signature	Lice			lame and Address o	of Facility Osk	orne Fu	neral Home	P.A.
Physician		23a. Part I. Enter the disease, or	complications that cause	sed the death.	Do not enter the	5 S.Conoc	cocheagi	ie St.	Williamspor	t,MD 21795 Approximate Interval
/Medical	8 0	failure. List only one cause Immediate Cause (Final disease	on each line. Mult:	ipte di	rug tox	icity inv	olving	Bupropi	on,	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co			е.Сптатор	ram and	Quetta	pine	
	P.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	nsequence of	F):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	с							
ecuted and transit	Exa	events resulting in death) Last	Due to (or as a co	nsequence of	1):					
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physiciae: The law requires that the death certificate be executed 24 hours after death.  Funceral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burnal - trans	Medical	X UNPENDED	X AMENDED 1	,23a,27	7,28a-f	per me,g	919 9-1	5-11 sm	l	
760 ficate l g physisthe bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, out				7		23d. Date of deliver	у
Box 6876 death certificate the attending phy	Physician/	past 12 months?	4 Pregnant	at time of dea	oth -	taldeath 3 _ ner (S <i>pecify)</i>	Ectopic pregn	ancy	Month	Day Year
BO) he deatl y the att hed for	hys		known 9 Unknowr							
F. P.O ires that to signed by	2	Part II. Other significant condit	ions contributing to de	eath but not re	esuiting in the u	nderlying cause giv	en in Part I.		obacco use contribute to s 2 No 3 Pro	
rds, require been si rould b	Completed							24a. Was	an 24b. Were au	utopsy findings available
e law te has te has te ge 2 sh	ם	-						autop	rmed? death?	completion of cause of
tal Rection: The certificate ector, page	Be	25. Was case referred to medical	1			26.Place o	f Death (Check	1 Yes	2 No 1 Y	es 2 No
of Vital Records, g Physiciae: The law require. The true certificate has been sineral director, page 2 should b.	일	examiner? 1 ✓ Yes 2 No			ER/Outpatient		ther Nursi	ng Home 5	Residence 6 Othe	r;
n of idiog P. h. After a funera		27. Manner of Death  1 Natural 5 Pend	28a. Date of (Month, Da	njury y,Year)	28b. Time of Ir		at Work? s 2 🗶 No		now injury occurred took drugs	
risio r Atter er deat irector	ficat	2 Accident Inves	stigation 1d 9-1		fd 8:15 me, farm, stree	t, factory, office bui			Street and Number or Ru	
Divis Bospital or A 24 hours after Fuecral Dire	Certification:	0010100	d not be mined (Specify)		idence		<b>G.</b>	or Town, S	tate)12213 Buc	ky Ave.
Di To the Hospital of within 24 hours a To the Fuocral I	ledical	29a. Certifier (Check only one) 2 Medical Example 1	nysician: To the best of	my knowledg	e, death occurr	red at the time, date	and place, and	due to the caus	e(s) and manner as stat and place, and due to the	ed.
To the withing To the company of the the the the the the the the the the	Medi	29b. Signature and title of certifie	and manner state	ed.		29c. License r		at the time, date :	and place, and due to the	
		6.4. A. DI	11-0/1	1/1/2	St	O.C.M.			September 2, 20	
	ŀ	30. Name and address of person	who completed cause of	of death (Item)	23a)				1	
		Victor Weedn MD JD	Assistant Medic			. Baltimore Str	eet, Baltimo	ore, MD 2122	23	
St Regist	ate rar	31. Date filed (MonSEP Year)	5 2011 32. Rans	trar's Signatur		west .				

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be in with the monte.

**Physician** 

Examiner

/Medical

ending physician and use as the burial-trar

attending p

signed by the aid be detached for

peen has Examine

Physician/Medical

\$

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

	d						
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery  Month Day Year						
Part II. Other significant conditions co					co use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		
REFLUX DIS		ESOPHA	(SEAC	24a. Was an autopsy performed 1 ∐Yes 2 ☑			
25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ ₩0	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I		eath (Check only one) Home 5 Residence	e 6 ☐Other (Specify)		
7. Manner of Death 1	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how i	v injury occurred eet and Number or Rural Route Number.		
29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	vsician: To the best of my kno	owledge, death occurre	ed at the time, date and plac on, in my opinion, death occ	ce, and due to the caus			
9b. Signature and title of certifier		2	9c. License number	204	Date signed (Month, Day, Year)		

D(8019

LAGERSTOWN,

AVRUST 23,2011

~10 21748

JW- 5 State

31. Date filed (Month, D

VASAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTAMO

340 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

MILL ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 28959 State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ рМ 2011 2359 Fonzie M. Garnett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number 6. Sex 1 ♣ M 2 ☐ F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day 1 920 Hanover Virginia 91 Yrs. Director 229-12-0963 Usual Residence of Decedent or 28a-f shov notified at show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director 1- Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or Funeral United States 1726 Jackson Street NE 20018 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Black If Yes, Give 3 Midowed 4 ☐ Divorced Year or Dates and Mental Hygiene.

is marked other than "naturanmatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Carpenters Union Carpenter 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ./AOFc,
nit. Page 1 and 2 shc.
and of Health and Me.
'them 27 is marked o.
ar traumatic ev. ည Lucy Twisdale Frank Garnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Windy Ridge Lane Newport News Virginia 23602 Terry Boston/ Neice permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Remo 8-23-2011 Brentwood, Maryland Fort Lincoln Denation 5 Other (Specify) rignature of Fineral Service 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death mmediate Cause (Final PLy ician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): lor Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Acute on Chronic Renal Failure, HTN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😾 No ER/Outpatient 3 DOA ၉ 1

Inpatient 2 □ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 🚻 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 8-16-2011 D0068681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charu Maheshwary, 1500 Forest Glea Rd. Silver Spring MD 20910 HCH 31. Date filed (Month, Day, Year) AUG 2 4 2011 State ack Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.

Amend 26 per DVR G919 9/12/11 dk

State of Maryland / Department of Health and Mental Hygien ( 28960 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death September 4, 20 II Physician/ Greenwood 3:50 Ethel pИ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Bowie 12306 Melody Turn If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 461-18-1563 **Director** 93 1 M 2 XF 2/20/1918 TX Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If ifew 27 is marked other than "natural", or items 23a or 28a-f sho and: If item 27 is marked other than "natural", or items 23a or 28a-f sho unty or other traumatic event, ithe Medical Examiner must be notified at Director Upper Marlboro MD Prince Georges 1 🗌 Yes 2 😾 No 10g. Citizen of What Country? 10f. Zip Code 20772 by Funeral 7305 South Osborne Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Hill 2 Isaac M. Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7305 South Osborne Rd. Upper Marlboro, MD 20772 Paula M. Martin, daughter Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/8/2011 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signarus of Funeral Ser M01539 Mercoffs 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tra Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 Month Year Day 5 Other (specify) Yes 2 No 1 Yes 2 g Unknown Hospital or Attending Physician: The law requires that the page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tes Yes 2 XN funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 X Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural injury 5 Pending Accident Investigation filled in by the s after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitionar To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Funer completely fi (Check Cartifying Nurse Practitionar To the best of my knowledge, death 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 2011 mo 37934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway (enter Drive Green belt AD 20770 Stephanie Trifoglismo 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 1 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 10:00 p.M Carolyn Elizabeth Gordon August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Kline Hospice House Airy Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 219-44-2994 **Director** 1 M 2 X 65 05/13/1946 Maryland show or 28a-f shove notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? ò ms 23a or must be i Funeral 4503 Baker Valley Road 21704 United States "natural", or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 10' Completed by 1 Never Married 2 X Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Mehrl Wilson Shultz, Sr. Edith Mackley Shultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4503 Baker Valley Road, Frederick, MD 21704 Joseph Gordon / husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10 T 1 XBurial 2 Cremation 3 Removal from State Department of Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 9/3/2011 Frederick, MD 22. Name and Address of Facility Keeney & Basford Funeral Home Signature of Funeral Service Licensee mulen In MO1222 106 E. Church St., Frederick, MD 21701 23a. Pan 1. Eiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ cancel disease or condition resulting in death) Metastalia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consuluence of cause. Enter Underlying Cause (Disease or injury Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Other (specify) Pregnant at time of death 1 ☐ Yes 2 7 g | Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes Yes 2 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence WHospice House မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the within To the 29c. License number 29d. Date signed (Month, Day, Year) မ

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D48184

09/01/2011

Street Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 201

			1 - State Registrar		(	Certificate	of Deat	h	Re	eg. No.	
	Physicia	n/	Decedent's Name (First, Middle, Las				2. Date of Death Month	Day Year			
	Medic		John W.	Gregg Jr				August	25 mg 501	1:37 A M	
	Examin	er	4a. Facility Name (if not institution, give	· ·			Town, or Locat			4c. County of Dea	
	Funeral		Northwast HS.  5. Social Security Number 6, Se	atal Cente	(In yrs. last birtho		days to	Mu nder 24 Hrs.	8. Date of Birth	Baltima	rthplace (State or Foreign
	Director		222-34-3089 Usual Residence of Decedent	TYM 2 DE	3 Y	Months	Days Hou		April 9	, 1948 De	Laware
	and show	5	10a. State 10b. County	1	10c. City, Town o	or Location					10d. Inside City Limits
	e Maryla r 28a-f notifiec	Director	MD Howard		E	llicott					1 🗆 Yes 🚈 No
	h with th ns 23a o nust be	Funeral	3312 Oak West Dri	ive		Tor. Zip	21043		1	09. Citizen of What C United St	,
9036	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.			ent of Hispanic fy Cuban, Mex 2 X No Spe	rican, Puerto F	cify Yes or No∽ Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
21215-0036	in 72 hou e. nan "natu Medica	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)		(0	ecedent's Usual Give kind of work fe. DO NOT use	done during r	most of workir	ng	16b. Kind of Business	Industry
	y within ygiene. <b>her tha</b> <b>rt, the N</b>	au I		4		mputer 1	Analyst	:		Government	Contractor
/land	ould be filed wii d Mental Hygie marked other matic event, th	To B	17. Father's Name (First, Middle, Last)  John Wesley G	Gregg, Sr.				lother's Name <b>Majori</b>	e (First, Middle, M .e Cra:		
Maryland	2 sho th an 27 is trau		19a. Informant's Name/Relationship (Ty Laurie G. Gregg/wi		19b. N	Mailing Address	(Street and Nu est Dri	mber or Rural	Route Number, C	City or Town, State, Z ity, Maryl	ip Code) and 21043
Baltimore,	e 5		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of D cemetery, Ardent	Disposition (Name crematory or other	her place)			20c. Location - City o	
<b>Baltir</b>	permit. Page Department Important: I any injury o	1	21. Signature of Funeral Service Licens	y H. Wit	11   Hanover, Maryland H. Witzke's Family F.H. Inc. Ellicott City, MD 21043						
_	40 = 60		23a. Part Enter the disease, or comp	Momao	ho dooth. Do not						
-	Physician/	9 5	shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.			or dying, sucr	i as cardiac of	rrespiratory arres	ot,	Approximate Interval Between Onset and Death
مس	Medical Examiner		resulting in death)	a. Due to (or as a c	0.000						hours
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a c	consequence of)						Louis
_	rificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	c. Esopho	consequence of)	Chnur					
8760	cate I	Medical		d							
Вох 6	death cer ne attendi ed for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at ti 9  Unknown	☐ Fetal death	3  Ectopic pr 5  Other (spe				23d. Date of de Month	elivery Day Year
s, P.O.	ires that the signed by do be detailed		Part II. Other significant conditions co	ontributing to death but	_	the underlying ca	ause given in F	art I.			o the cause of death?
cord	law requ has been le 2 shoul	Completed by							24a. Was an autopsy	y prior to	utopsy findings available completion of cause of
Ä	sician; The la certificate ha rector, page	Co	05 W						1 Yes 2		s 2 No
ita	siciar certif irecto	Be c	25. Was case referred to medical examiner?  1 Yes 2 □ No	Hospital:			Other:	Death (Check			
n of V	<b>ting Phys</b> n. After this funeral dii	ate: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, )	t 2 ER/Outp 28b. Tim Year)	ne of 28	c. Injury at work?	2	ne 5 ☐ Resider 8d. Describe hov	nce 6 Other (Spe w injury occurred	<u>cify)</u>
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			, street, factory,	1 Yes 2	_	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	Hospita 24 hours Funeral leted filled	Medical	(Check 2 ☐ <b>Medical Examir</b>	ician: To the best of my ner: On the basis of exam re Practioner: To the be	mination and/or i	rvestigation, in m	v opinion, deat	h occurred at t	the time, date and	place, and due to the	cause(s) and manner stated.
	To the within 2 To the Comple	2	29b. Signature and title of certifier		or or my knowled	29c.	License numb	er	29	d. Date signed (Mont	th, Day, Year)
			· OYAK	2 mo			10056	632	/	Hignet 2	500 2011
ı	2		30. Name and address of person who co	ompleted cause of dea		pe, Print)	\ <del>-</del>	ב מ	Y 1	11.54	2 <sup>nd</sup> 2011
	Stat Registra		31. Date filed (Month Aug 2 4 2	011 32. Begistrar's	s Signature	Spark	HAK T.	رظ	nama	in in in in in in in in in in in in in i	THE ALLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NaZ 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lloyd Kelvin Gerald 10,201 710 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation + Nursing C 5. Social Security Number 6. Sex 7. Age (In yrs. last bithda Wicomico lisbu If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hre 6. Sex 1 → M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days July 4, Hours Min. Maryland Yrs. 220-32-8010 Director 75 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and the files 23a or 28a-f sho and the files 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4180 Allen Road 21822 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🛛 Yes 2 1957 - 1959

If Yes, Give 1957 - 1959

Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired; Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Veteran's Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rev. Charles David Gerald Malinda Jane Polk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. Malinda Gerald/mother Allen Road - Eden, Maryland 21822 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/18/2011 Salisbury, Maryland Salisbury Crematory 21 Sig atur. Forera Service Licens 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD Bal OLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on , ach line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition ears Medical resulting in death) Examiner las Sequentially list conditions, if any, leading to immediate Examine cause. Emer Underwind Cause (Disease or iinjury that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 10 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 1 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d Date signed (Month, Day, Year)

€ 7° NA State

0

DHMH 17 Rev 7/2009

Registrar

AVIC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M,

Registrar's Signature

Rob

16

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28964 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26 2011 Herbert Alexander Hill  $P^{M}$ July 9:29 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HCR ManorCare Prince Georges Largo 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 21, 1 Birthplace (State or Foreign Country) Security Number **Funeral** Days 1 🖾 M 2 🗆 F Months Min. Hours Director 229-50-3982 1940 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No MD Upper Marlboro Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3614 Halloway North 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2K No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Building Engine</u>er Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Edward Hill Margarite Brown 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halloway North, Upper Marlboro, Delores White/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wilkerson Mem. Cem8/6/2011 Petersburg, VA Signature of Fineral Service Licen 22. Name and Address of Facility Austin Royster Funeral Home lows 3821 14th Street NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Weeks Immediate Cause (Final ₽hysician/ Congestive Heart Failure Medical Examiner resulting in death) Due to (or as a consequence of) Months Cardiomyopathy Sequentially list conditions, if any leading to in neclate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consecuence of vsician and sucial trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death Yes 2 No the detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à funeral director, page 2 should be Division of Vital Records, Chronic Obstructive Airway Disease 1 Tes 2 No 3 Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HIV/AIDS has autopsy performe certificate Deep Venous Thrombosis 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this ompleted filled in both. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier In toye 2011 1005143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Ibitoye

AUG 2 4 2011

37. Registrar's Sig

31. Date filed (Month, Day, Year)

MD 12200 Annapolis Road, Glen Dale,

MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28965 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201<sup>rear</sup> Halloran 20, 10:55 am Norbert Anthony August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington Park Retirement Community Kensington If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ Months Hours Feb. 7, 1922 89 470-16-8809 MN **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location aţ Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🔼 No Montgomery Kensington MD 10e Street and Number 10g. Citizen of What Country? USA 20895 3620 LIttledale Road, Woodlands 316 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Armed Forces? Black, White, etc. 1 Never Married 2 Married Specify White þ 72 hours after Maryland 21215-0036 ner than "natural", c t, the Medical Exam 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced Completed WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Attorney other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F ပ္ Inga Johnson John Halloran permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10812 Lorain Avenue, Silver Spring, MD 20901 Stephanie Halloran/Daughter 3altimore, Date 23, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Aug. 2011 cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis Adrecoff The Funeral Home Inc. Allian 500 University Blvd. W., Silver Spring, Md 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Neoplasm of Lung Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial managed. B Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Munknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DCA ည 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred iniury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the I within 2 To the F only one) 29d. Date signed (Month, Day, Year) August 23, 2011 29b. Signature and title o D34032

10+1

DHMH 17 Rev 7/2009

State Registrar 30. Name and ad

Asher,

(Month, Day, Year) AUG 2 4 2011

Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print) sher, MD 3720 Farragut Avenue, 2nd Floor, Kensington, MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene										
			State Registrar	eg. No 20	28966							
	Physicia	ın/	Decedent's Name (First, Middle	, Last)				Date of Death     Month	Day Year			
	Medic		Douglas		lickcox			August	1:10 AM			
	Examin	er	4a. Facility Name (if not institution			4b. City, Town, or l		1	4c. County of Dear			
-	Euroval		Anne Arundel M 5. Social Security Number		er ge (In yrs. last birthday)	Annapo If Under 1 Year		8. Date of Birth	Anne Ar	thplace (State or Foreign		
	Funeral Director		399-52-4791	1 🕅 M 2 🗆 F	61 Yrs.	Months Days	Hours Min.	12 <sup>Mo</sup> 059 <sup>Da</sup> 19	749 Wis	consin		
	- MC		Usual Residence of Decedent		1							
	yland -f shc ed at	Director	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	- 28a- notifi	jre		Arundel	North					1 ☐ Yes 2 🏋 No		
	ith th	ral	10e. Street and Number		80717	10f. Zip Code	,	1	0g. Citizen of What Co USA	ountry?		
	ath w	Funeral	7050 Albany Av	12. Was Decedent	20714 Ever in U.S. 13. A	2071 Vas Decedent of His		ecify Yes or No-	14. Race - Ame	orican Indian		
9	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		1 Never Married 2 X Marr	Armed Forces?	l No	f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, Whit			
03	ırsaft <b>ıral</b> ", IExal	ed	3 🗆 Widowed 4 🗆 Divorced	If Voc Civo		☐ Yes 2 🔏 No	Specify:		Specify: V	White		
5-(	2 hou "natu	Completed by		nt's Education est grade completed)	16a. Deced	lent's Usual Occupat kind of work done du		king	16b. Kind of Business	Industry		
121	thin 7	МÓ	Elementary/Seconday (0-12)	College (1-4 or	5+) life. D	O NOT use retired)			Escaptos	on.		
d 2	교육	Be (	17. Father's Name (First, Middle, L	4	Farr		18 Mother's Nar	ne (First, Middle, M	Equestri	an		
Maryland 21215-0036	should be file n and Mental I 7 is marked o raumatic eve	<sup>2</sup>	Derald Donal	_			01ive	Gavle	Thomas			
ary	1 and 2 should be fi of Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street ar			City or Town, State, Zi	p Code)		
	d 2 stalth a alth a 127 is		John D. Hickco	x, Son		Albany A			-	714		
ore,	a. 0 - 1		20a. Method of Disposition 1 ☐ Burial 2 ሺ Cremation	· · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo		- 1		20c. Location - City or	Town, State		
<u>Ĕ</u>	Page ment o ant: If ury or		4 Donation 5 Other (S		Metropoli		· :	23-11	Alexandr	ia, VA		
Baltimore,	permit, Page Department Important: I any injury o		21. Signature of Funeral Service L	icensee		. Name and Address			eral Home,			
_	= @ ol		Millian	K. Gre		325 Mt. H				0736		
			23a. Part 1. Enter the disease, or shock, or heart failure. List of			er the mode of dying.	, such as cardiac	or respiratory arres	st,	Approximate Interval Between		
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ aK	a consequence of):	- FAILLA	2			Onget and Death		
-	Examiner				PAYS							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):							
	uted d ansit	Examiner	Cause (Disease or iinjury that initiated events		PANCAGA		0075					
	ite be executed hysician and he burial-transi	E E	resulting in death) Last	Due to (or as	a consequence of):					DECADES		
9		dical		d	ALCOHO	C 054				1) ((1)		
Box 687	death certifica he attending p ed for use as i	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							
XO	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	elivery Day Year		
m	9 P 9	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of death of E	- Curici (specify)						
P.O.	The law requires that the de- rate has been signed by the a page 2 should be detached	by PI	Part II. Other significant condition	ons contributing to death t	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
	uires n sign	ed b	llerel fail	ve				1 □ Ye	s 2 No 3 F	Probably 4 Unknown		
Ö	w req	autopsy prior to comp								topsy findings available completion of cause of		
Rec	The Is ate his page											
<u> </u>	sian: ertific ctor,	Be (	25. Was case referred to medical examiner?		1-24	26. Plac	ce of Death (Che	ck only one)				
Ξ	Physic this c al dire	မ	1 Yes 2 W No		ient 2 ER/Outpatier		4 U Nursing F		nce 6 Other (Spec	cify)		
0 0	ding F h. After funer	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin			work?	at ∕es 2 □ No	28d. Describe hov	w injury occurred			
Siol	Attend deatl ctor: y the	≝	2 Accident Investig 3 Suicide 6 Could	not be	ury - At home, farm, stre		res 2 🗆 No	28f Location (Str	eet and Number or Ru	ural Route Number		
Division of Vital Records,	al or A s after Direction b		4 ☐ Homicide determ	building, et	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,		Tal Floate Hallies		
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying	Physician: To the best of	f my knowledge, death o	occured at the time,	date and place, a	nd due to the caus	e(s) and manner as st	ated.		
	the Ho lin 24 the Fu hplete	Med	(Check 2 ☐ Medical E only one) 3 ☐ Certifying	Nurse Practioner: To the	e best of my knowledge, o	igation, in my opinion death occurred at the	i, death occurred time, date and pla	at the time, date and ace, and due to the d	d place, and due to the cause(s) and manner as	cause(s) and manner stated. s stated.		
	0 = 0 E		29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mont	h, Day, Year)		
	F S F O											
						TD.	7214	1	812 49			
9	10. Tw		30. Name and address of person v		death (Item 23a) (Type, F	rint)	7214	1 1 2	7/2 49			
		e	7 7	our medi	death (Item 23a) (Type, F	rint) way A	72/140	, md a	7/2 49			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		- For		State of M	laryland	d / Dep	artment of I	dealth a	and M						
		State Registrar				Ce	rtificate of l	Death			Reg. N	20		289	167
Physicia	n/	1. Decedent's Name (First,		,						2. Date of Dea		25	oYear a	3. Time of	
Medic	al			Hufford			1			August			2011	1648	М
Examin	er	4a. Facility Name (if not ins. 10737 Brool	_		Λnt	1	4b. City, Town, o	r Location of			4		y of Death <b>Vashin</b>	aton	
Funeral		5. Social Security Number	6. Se	7. Ac	ge (In yrs. Ia:		If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birt	th		9. Birthp	lace (State o	r Foreign
Director 195–42–2951 1 M 2 □ F 57 Yrs. Months 1								Hours	Min.	Dec. 7,	×195	3	Count	Ohio	
nd at	Ŀ	Usual Residence of Deceder 10a. State 10b. 0	ent County		10c. City	, Town or L	ocation						10	Od. Inside Cit	tv Limits
arylar a-f sh ified	ecto	Maryland	-	ngton		, , , , , , , , ,	Williams	sport							2 🗆 No
or 28	ä	10e. Street and Number	Washi	1190011	1			10g. Citizen of What Co				try?			
s 23a	Funeral Director	10737 Brook	kmeade	Circle A	Apt. 4		23	.795		US					
death ritem ner n	F	11. Marital Status		12. Was Decedent Armed Forces?		. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)			ce - America ick, White, e		
after al", or xami	d by	1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ If Yes, Give Year or Dates					1 ☐ Yes 2 🔀 No	Specify:				Specify		hite	
hours natura lical E	Completed	15. D	ecedent's Ed		197 	16a. Dece	edent's Usual Occup	ation			16b.	Kind of E	Business Ind		
in 72 e. han "ı	gmc	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)					e kind of work done DO NOT use retired)		of working	9				_	
d with tygien ther th	Be C	12					Machir						el Mil	<u>. T</u>	
rintal H ced of	일	17. Father's Name (First, Middle, Last)								(First, Middle, Nicho]		1 Surnam	ne)		
ould but Me in mark			Robert Hufford  19a. Informant's Name/Relationship (Type, Print)				ling Address (Street	Fay and Number				or Town.	State. Zip C	ode)	
alth al alth al 27 is ar trau		Connie Huffe					37 Brookme								2179
of Her of Her fitem		20a. Method of Disposition				ace of Disp	position (Name of ematory or other place			ate			- City or To		
Page ment tant: I		4 Donation 5 C			_	rstow	n Cremato	ry A				jerst	own,	Maryla	and
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of uneral S	Licens	<b>F</b>			sborneade							WD 0:	700
GD = # 0		23a Part 1. Enter the dise	0/0	licetions that equal	d the death		25 S. Cor					.amsp	ort,	_	1795
		shock, or heart failure Immediate Cause (Final	e. List only or	ne cause on each lin	ie.						,631,			Approximate Interval Bet Onset and I	ween
Physician/ Medical		disease or condition resulting in death)		a Due to (or as			MIAL	(NP	7/~						
Examiner		Commentally link on elikings		b. ———	·										
T #	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying	te	Due to (or as	a consequ	ence of):									
ecute and -trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	1	c. Due to (or as	ence of:	<del></del>									
be ex sician burial	dical	rosanny masany aust	L	,											
iath certificate be executed attending physician and for use as the burial-transit	<b>Jedi</b>			d											
endin r use	Physician/Me	IF FEMALE: 23b. Was decedent pregna	u it	23c. If yes, outcome			Ectopic pregnan	CV					ate of delive	*	
the att	/sici	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	· ·	4  Pregnant 9  Unknown			Other (specify)		Month Day				Day \	Year	
at the	Ph.	Part II. Other significant c			but not resu	ılting in the	underlying cause gi	ven in Part I.	l.	23e. Did to	obacco	use con	tribute to th	e cause of d	eath?
signe d be	d by	DIABETES							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unkn					Unknown	
v requ	Completed									24a. Was		24b.	Were autop	sy findings a	available
he lav te has	mo										psy ormed? 2 4	No.	death?	npletion of c 2 □ No	ause of
ian: T	BeC	25. Was case referred to m examiner?	-					lace of Deat	th (Check o		2 621	10	1 1 100		
hysic this ce	မ	1 Yes 2 No					ent 3 DOA Oth	4 L. Nu		ne 5 Resid					
Jing F h. After t funera	ate:		Pending	28a. Date of inj (Month, Da	ury ay, Year)	28b. Time ( injury	worl			3d. Describe h	now inju	iry occur	red		
Attend r deat ctor: y the	Certificate:	3 Suicide 6 🗆	Investigation Could not be determined		jury - At hor	ne, farm, s	M 1 L	res Z 🗆		8f. Location (S	Street a	nd Numt	per or Rural	Route Numb	oer,
s after selection of the selection of th		4 - Homicide	determined	building, e	tc. (Specify)					City or Tou	vn, Stat	e)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier 1 Certifier (Check 2 Me	rtifying Phys	sician: To the best o	f my knowle examination	edge, death	occured at the time	e, date and p	place, and ccurred at t	due to the ca	use(s) a	and mann ce, and di	ner as stated	d. ise(s) and ma	nner state
the lithin 2 the l	Me		rtifying Nurs				, death occurred at the	e time, date			e cause	e(s) and m		ited.	
5.¥5.8		255, Oignature and title	·	aus 1	W.			1282			zau. D	_		S - //	,
		30. Name and address of p	person who c	completed cause of	death (Item	23a) (Type,		1202							
W-4		Samuel Rao	, M.D.	3 Byrk	it Dr	ive	Williamsp	ort,	Mary.	land	217	'9 <u>5</u>			

JW- 4 | State

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day Yes 9 2011

DHMH 17 Rev 7/2009

	end 23a,1 t II per		I,b and Please Type or					•		•			
	O Health	•	State of Maryland / Department of Health and M  1 - State Dept. 8-30-11 KAH  Certificate of Death						Reg. No. 2011 28961				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	4	HollAND						3. Time of Death		
	Medic Examir	al	4a. Facility Name (if not institution, give street and num.		11191		r Location of Deat	Month b	19	Year 2011 County of Deat			
-	Examili	er	Anne Arundel Medical	-	er	Annag			40.		Arunde1		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 G F	7. Age (In yrs. I	ast birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.						
5/	Usual Residence of Decedent  Decedent										10d. Inside City Limits		
	Maryla 28a-f s otified	irect	Maryland Anne Arundel	Cl	nurch	ton					1 ☐ Yes 2 🔀 No		
	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5730 Shady Side Rd.			10f. Zip Code 2073	33		10g. Cit	izen of What Co	untry?		
l	r death or item iner n		11. Marital Status 12. Was Dece Armed For 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes	dent Ever in U. ces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	-	14. Race - Amer Black, White			
Baltimore, Maryland 21215-0036	rs afte iral", c	ed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv. Year or Da	9		1 ☐ Yes 2X No	Specify:			Specify: B1	ack		
15-0	72 hou n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	edent's Usual Occup kind of work done	during most of wo	rking	16b. K	ind of Business I	ndustry		
212	within giene. er thar the M	Con	Elementary/Seconday (0-12) College (1-12) College (1-12)	4 or 5+)		DO NOT use retired) ervisor		ler	Ku	randa 1	USA		
pu	filed via Hyg	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle		Surname)	ne)		
ryla	d Men marke matic		Blake A. Holland Sr  19a. Informant's Name/Relationship (Type, Print)		T.o.			ie Blur		T 01 1 7	0.11		
Ma	d 2 sho alth an 27 is er trau	Ì	Caroline C. Holland(	Wife)	T	ling Address (Street  O Shady							
ore,	of He If item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from	State 20 <b>H</b>	labelof DS: cemetery, cre	psec (Name of ematory or other place	ce)	Date	20c. Lo	ocation - City or	Town, State		
tim	it. Pag rtment rtant: njury o		4 Donation 5 Other (Specify)	Me	emori	al Garde	ens   8-2	26-11		napoli:			
Bal	permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medi	- (	21. Signature of Funeral Service Licensee  Winame a Richers of F&ilit Sons Mortuar 1922 Forest Dr. Annapoli										
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betwee										
	Ph, Medical Medical Examiner physician and the bruial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	or as a consequence as a consequence or a consequence or a con	uence of):	Failure					13 vears		
. Box 68760	law requires that the death certificate be has been signed by the attending physic is 2 should be detached for use as the bi	Physician/Medical		Birth 2 🗀 Feta nant at time of a	al death 3	☐ Ectopic pregnand☐ Other (specify) _	су			23d. Date of deli Month	ivery Day Year		
s, P.O.	ires that the signed by		Part II. Other significant conditions contributing to de	eath but not res	sulting in the	underlying cause gi	ven in Part I.				the cause of death?		
of Vital Records,	w requ s been 2 shoul	Completed by	HYARATENSION	24b. Were aut	opsy findings available completion of cause of								
Rec	The la ate ha page 2	Com	PROSTATE CAN	cer				auto perfe 1 🗌 Yes	ormed? 2 KNo		2 No		
ital	sician: certific rector,	Be	25. Was case referred to medical examiner?			Oth	lace of Death (Che						
of V	g Phys er this eral di	e: To	27. Manner of Death 28a. Date	Inpatient 2 🔀 of injury h, Day, Year)	28b. Time of	of 28c. Injur	4 ∐ Nursing F y at	dome 5 Resi 28d. Describe			fy)		
ion	tendin eath. or; Aft the fur	itical	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	i, Day, rear)	injury	M 1 □	Yes 2 No						
Division	l or At after d Direct I in by	Cert	4 Demiside determined 28e, Place	of Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, st	reet, factory, office		28f. Location ( City or To			al Route Number,		
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director, After this certificate he completed filled in by the funeral director, page	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the be										
	the H thin 24 the Fi		(Check 2 ☐ Medical Examiner: On the basionly one) 3 ☐ Certifying Nurse Practioner: 729b. Signature and title of certifier			death occurred at th	e time, date and pla		ne cause(s	) and manner as	stated.		
o	<b>7</b> × <b>2</b> 00		Stephen Haron	ه د د د در	MX	D 2	7200	.	24	e signed (Month	7011		
	2/4	ŀ	30. Name and address of person who completed caus	e of death (Item	23a) (Type,	Print)	, , , ,				TER MD 2103		
	7 18		A. Stephen Haiusm, B1. Date filed (Month, Day, Year) 32. Be	4 س , الم gistrar's Signa	7 M	itchells	ChAR	cekb	L, Fo	lgew.4	TER 140 2103		
	Stat Registra	e .	AUG 2 4 2011	www.	B. A	back							

	nd #20ape		0.04.44.70**				=			
AAL.	) њеатат г	æµ	t. 8-24-11 KAH State of Maryland / State of Maryland / Registrar	•	irtment of tificate of		and Mental F	lygien Reg. N	0011	22969
	Physicia	n/	Negistrar     Decedent's Name (First, Middle, Last)		unout :	<i>D</i> 0	2. Date of	Death	Day O Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give street and number)				Month	00	0011	∂347 M
	Examir	er			4b. City, Town,			4	Ic. County of Deat	
	Funeral		Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday)	If Under 1 Year		24 Hrs. 8. Date of			thplace (State or Foreign
JA.	Director		192-28-1654	2 Yrs.	Months Days	Hours	Min. Feb	28 Year	939 Pei	nnsylvania
	land show dat	tor	10a. State 10b. County 10c. City, To:	wn or Loc	ation					10d. Inside City Limits
	e Maryland r 28a-f sho notified at	irec		apo1	_	·				1 ☐ Yes 2 🏋 No
	ith the 3a or st be n	Funeral Director	10e. Street and Number  9 Rickover Ct.		10f. Zip Code 2140			10g. (	Citizen of What Co	ountry?
	death with t items 23a ner must be	nne	11. Marital Status 12. Was Decedent Ever in U.S.	13. V			ain? (Specify Yes or N	0-	USA 14. Race - Ame	rican Indian
9	s after dea ral", or ite Examiner	by	Armed Forces?  1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No				gin? (Specify Yes or N , Puerto Rican, etc.)		Black, White	
8	2 hours aft "natural", edical Exa	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.		Yes 2X N				Specify: B.	lack
21215-0036	7 a	Completed	(Specify only highest grade completed)	(Give k	ent's Usual Occu ind of work done ) NOT use retired	during most	of working	16b.	Kind of Business	Industry
	iled within 7. I Hygiene. other than	ပ္ပို	Elementary/Seconday (0-12) College (1-4 or 5+) College (1-5 or 5+) College (1-5 or 5+) College (1-6 or 5+)	lsso.	ciate <i>P</i>	Admini	istrator	Fe	deral (	Government
Maryland	e filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)				er's Name (First, Mida			
aryl.	of Health and Mental I of Health and Mental I fitem 27 is marked o r other traumatic eve	ľ	Thomas Hunt  19a. Informant's Name/Relationship (Type, Print)  15	9h Mailin	n Address (Stree		er W. Bu r or Rural Route Num			Code
	d 2 sh alth a 1 27 is ertrau		Mary Ann Hunt(Wife)		-		Annapoli			
ore,	of He of He If item r othe				ition (Name of atory or other pla		Date		Location - City or	
Baltimore,	t. Page tment tant: I		4 Donation 5 Other (Specify) Fintanhement Memo	oria	1 Garde	ens 8	8-29-11		napolis	
Bal	permit. Page 1 a Department of H Important: If ite any injury or off		21. Signature of Funeral Service Licensee				Sons Mor		_	
			23a. Part 1. Enter the disease, or of implications that caused the death. Do				Dr. Anna cardiac or respiratory		s, <u>M</u> a.	Approximate
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	٥	OWN	Care	hal 4	Da	uctu-	Interval Between Onset and Death
ų,	Medical Examiner		resulting in death)  a.  Due to (or as a consequence)	e of):		le.	1 01		and	
		Jer	if any, leading to immediate Due to for as a consequence	e Øf):	1 7		7 000	30	0	
	executed an and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  c.	Dec	Jeul	riel	arlange	100	المحدد	
	ath certificate be executed attending physician and for use as the burial-transit	_	resulting in death) Last Due to (or as a consequence	e 80:						
68760	cate b physic	edic	d							
89	certifi ending use as	M/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal dec	oth 2	Ectopic pregnar	201		1	23d. Date of del	ivery
Box	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown		Other (specify)	icy .		-	Month	Day Year
P.O.	at the	Ę	Part II. Other significant conditions contributing to death but not resulting	g in the ur	derlying cause g	jiven in Part I.	. 23e. Did	d tobacco	use contribute to	the cause of death?
ls, F	uires ti n signe	d be	1. Cerebral Veseul	لو	Occ	ula	15	Yes 2	2 □ No 3 □ Pr	obably 4 🗆 Unknown
örc	iw req	plet	3. Hypertensia				24a. Wa	as an topsy		topsy findings available completion of cause of
Rec	The la	ا ق	3 Hyperupalania	2			pe	rformed? s 2 🔀	death?	2 🗆 No
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?				h (Check only one)			
γV	Physical chiral chiral chiral	유	1 Inpatient 2 ER/C	Outpatient	3 DOA 28c. Inju		rsing Home 5 Re			ify)
ouo	ath. r: Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident ☐ Investigation	injury	wor	rkí? ∐Yes 2 ☐ l	l l	o 11011 111ju	, 000000	
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, the building, etc. (Specify)	farm, stre	et, factory, office			(Street a	nd Number or Rur e)	ral Route Number,
۵	spital ours a neral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e death o	ccured at the time	e date and n	lace and due to the	cause(s) a	and manner as sta	ted
	he Ho	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and only one) 3 ☐ Certifying Nurse Practioner: To the best of my known of the basis of examination and only one)	d/or investig	pation, in my opin	ion, death occ	curred at the time, dat	e and place	e, and due to the o	ause(s) and manner stated.
_	To t To t		29b. Signature and title of certifier	0	29c. Licens	se number	1.00	29d. D	ate signed (Month	, Day, Year)
U	NY C	-	30. Name and address of person Whorcompleted gause of death (Item 23a)	NTVD. Pr	/ 100	007	707	0	2 93	Z N I
_	4.0		ERROY A- Yhillipmi), Or	C00	Medi	eal	Rusy,	30	m.er	1041EX
	Stat Registra	-	31. Date filed (Month, Day, Year)  AUG 2 4 2011  32. Redistrar's Signature	1 1	-41				-	

Baltimore, Maryland 21215-0036 enderson,

Division of Vital Records, P.O. Box 68760

amend #20 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ LAVENTA 8:00 A M HENDERSON 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE 'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Hours 1 🔀 M 2 🗆 F 0870871968 **Director** 578-82-4601 43 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1X☐ Yes 2 ☐ No MD PRINCE GEORGE'S NEW CARROLLTON 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral UNITED STATES 5420 85TH AVE. 20784 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ BERNICE WATSON JAMES HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5420 85TH AVE. #202, NEW CARROLLTON, MD 20784 BERNICE HENDERSON/ MOTHER 20a. Method of Disposition 20c. Location - City or Tow Riverdale, MD 9/0272011 Riverdale to Parker Crem. ➡<del>Sor</del>ial XX Cremation 3 ☐ Removal from State 4 Donation 5 Other (Special Fort Lincoln Cemetery: 8/27/2011 21. Signature of Funeral Service 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure List only one cause on each line Onset and Death Immediate Cause (Final Physician) disease or condition resulting in death) Medical Examiner S quartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has page 2 1 ☐ Yes 2 🛣 No 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 5 Pending Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and title of c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Royce A. Burns, MD (auham, MD. 20706 600d hack . Date filed (Month, Day, AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	arylanc		rtment of tificate of		nd M		giene Reg. No.	011	28971
	Physicia	n/	1. Decedent's Name (First, Middle,							2. Date of Dea	ath Dav	Year	3, Time of Death
	Medic	al	MARGAREI B. HAMMOND						Daath	AUGUST 20 2011   12:25			
	Examin	er	1112 WINDING B				BOWIE	or Location of	Death			ounty of Deat	EORGE'S
	Funeral				e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days			8. Date of Birt (Month, Day MARCH	h (' Š <sup>ear)</sup> l O.'	9. Bir	thplace (State or Foreign untry)
	Director ≥		Usual Residence of Decedent	A   0.		115.				MARCH .	10 194	20 PA	
	yland -f sho ed at	ctor	10a. State 10b. County			Town or Loc	ation						10d. Inside City Limits 1 1√2 Yes 2 □ No
	he Mai or 28a notifi	Dire	MD PRINCE  10e. Street and Number	E GEORGE'S	BOW	IE	10f. Zip Code				10a. Citize	n of What Co	21
	with t s 23a ust be	Funeral Director	1112 WINDING BE	ROOK COURT			2072	1			USA		
0000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. A property is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent E Armed Forces? ed 1 ☐ Yes 2 X If Yes, Give Year or Dates.		If	/as Decedent of Yes, specify Cult Yes 2 X N	an, Mexican,	n? (Spec Puerto R	eify Yes or No- Rican, etc.)		. Race - Ame Black, Whit ecify: B	
2	72 hou "natu edical	Completed	15. Deceden (Specify only highes			(Give k	ent's Usual Occu	during most of	of workin	g	16b. Kind	of Business	Industry
717	vithin 7 jiene. er than the M		Elementary/Seconday (0-12)	College (1-4 or 5	+)		NOT use retired				GOVI	ERNMEN	Т
alla.	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, La		•			18. Mother		(First, Middle,			
r yla	ould be d Men marke matic	-	MARION BEAR  19a. Informant's Name/Relationshi		:-	10h Mailin	g Address (Stree		SIE		OHNSO		n Code)
<u>,</u> ⊠	and 2 sho Health an tem 27 is other trau	59	MARY A. HAMMON				WINDING						
pallimore	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cei	metery, crem	sition (Name of natory or other pl TION CEM	ece) ETERY		ate /2011		•	Town, State  RYLAND
ספוו	permit. Page 1 Department of Important: If it any injury or o	(0	21. Signature of Funeral Service Li	Hento			Name and Add	-					AL HOME, INC. LAND 20785
~ · v.	huician/		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition	complications that caused aly one cause on each line	<b>.</b>	Do not ente							Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate	b. HYPER'									
	cuted and transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. SEPSI Due to (or as a		200 00:							
	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a	a conseque	nice oi).							
00/0	ificate ng phy as the	Medi	IF FEMALE:	_ u									
DOX 00	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  or the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	23c. If yes, outcome of the state of the sta	2 Fetal	death 3	Ectopic pregna Other (specify)	ncy			23	d. Date of de Month	olivery Day Year
	ires that th signed by Id be detac	þ	Part II. Other significant condition ASPIRATION PNI		ut not resu	lting in the u	nderlying cause (	given in Part I.					o the cause of death?
ecords,	aw requas beer 2 shou	Completed								24a. Was auto	osy	prior to	utopsy findings available completion of cause of
ב	r: The icate h icate h		25. Was case referred to medical			_			(0)	1 Tes	2 X No	death?	s 2X No
וום	ysicial s certif	To Be	examiner?  1 Yes 2 X No	Hospital:	ent 2 $\square$ F	R/Outpatien	I o	Place of Death			dence 6	Other (Spec	cify)
0 10	ath. ath. r: After thi ne funeral o	Certificate: 1	27. Manner of Death  1 XNatural 5 Pending 2 Accident Investig	28a. Date of injur (Month, Day ation	ry 2	28b. Time of injury	28c. Inj		2		ssidence 6 Other (Specify) e how injury occurred		
DIVISION	tal or Atters after de al Directo ed in by the	7	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 286. Place of Inju	. (Specify)					City or Tow	vn, State)		ural Route Number,
	ne Hospi n 24 hou ne Funer oleted fill	Medical	29a. Certifier 1 Certifying (Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	my knowle xamination best of my	dge, death o and/or invest knowledge, o	ccured at the tin igation, in my opi leath occurred at	ne, date and pl nion, death occ the time, date a	lace, and curred at t and place	d due to the ca the time, date a e, and due to th	use(s) and i and place, ai e cause(s) a	manner as st nd due to the and manner as	ated. cause(s) and manner stated. s stated.
	To the withing the To the complex comp		29b. Signature and title of certifier		(1)	( A )	29c. Licer	se number	10				rh, Day, Year)
	10		30. Name and address of person w	Much completed cause of the	(M	220) (Time 17	I DC	1064	69	0 .	AUGU	ST 22,	2011
R	-			RGE M.D. 750			PKWY SU	JITE 10	1A G	GREENBE	LT,MA	RYLANI	20770
	Stat Registra		31. Date filed (Month, Day, Year) AUG 2 5 2011	32. Register									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 28972 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ HENRY 08 0110 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salis Regional Medical Cente 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
52. Yrs. If Under 24 Hrs. 8. Date of Birth Birthplace Country) **Funeral** 1 **■** M 2 □ F Min Month, Day, 195 Hours Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Funeral Director NANTICOKE WICOMICO 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HANTICOKE DD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ori Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MECHANIC AUTO REPAIR permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, to onee. Be 8 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TINA HURIZY (WIFE NANTICOKE RD NANTIOKE, MD 21840 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 848-2011 JIANTICOKE, MID RIVERS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) alcoholic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of. the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Day Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes tulu Completed destridia difficile 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe 1 Yes 2 No certificate Yes within 24 hours after death.

To the Funeral Director: After this certificy completed filled in by the funeral director, it 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Datersigned (Month, Day, Year) 8 30. Name and address of per rson who completed cause of death (Item 23a) (Type, Print)

BK

Registrar

State

16

AUG

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Year ZOII 22/8 PM AUDUST Grover Wilson Hearn Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death HICOMICO Kegional TENINSULA 54/1564/4 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F 07-10-191 Months Davs 222-07-5063 94 **Director** Del<u>aware</u> Usual Residence of Decedent show 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No DE. Sussex Laure1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16807 19956 Laurel Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elmer Wilson Hearn Cynthia Lavenia Holston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16807 Laurel Road Frances M. Hearn Laurel, DE. 19956 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Church Cem. 08-18-2011 Laurel, DE. Signature of Funeral Service Li 22. Name and Address of Facility once. 700 West Street Laurel.DE. 19956 Hannigan, Short, Disharoon FH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MGO cardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of: Grovas that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has r this certificate has eral director, page 2 performe 2 No 2 PN 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at After Natural 5 Pending work n 24 hours after death.

le Funeral Director: A pleted filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2.

To the F
complet 0 NOTE

the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

State Registrar only one

29b. Signature and title of certifier

16 201 AUG

St. Salisbury MO

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10gPer FH C919 9/26/2011 JH State of Maryland / Department of Health and Mental Hygiene 28974 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 28, 2011 11:59 P M GERTRUDE B. IWANIUK Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death CHESTERTOWN KENT 121 MALONE AVENUE Czechoslovakia If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F 07/04/1921 Director 220-32-1522 90 Usual Residence of Decedent 23a or 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Examiner must be notified at Director 1 XYes 2 No **KENT** CHESTERTOWN MD 10g. Citizen of What Country?

Germany

UNITED STATES 10e. Street and Number 10f. Zip Code Funeral 121 MALONE AVENUE 21620 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILHELMINA BEER ANTON BEER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 MALONE AVENUE CHESTERTOWN, MARYLAND 21620 MICHAEL IWANIUK / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 08/30/2011 STEVENSVILLE, MARYLAND . Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Progressive Sumamuelour Palsy Ph sician/ 5 years disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p as IF FEMALE JSe S 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Por Day Pregnant at time of death signed by the a a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? and over cular 1 🗌 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l autopsy certificate Yes 2 THO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Dav. Year) 12011 1600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

anectour

5/6 Woshington

32. Registrar's Signatur

Koss

AUG 30

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ENCE 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Tate Hospice House Linthicum Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director Umuahia, Nigeria 579-17-7503 1 1 M 2 7 F 1944 67 Jan. 30. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Bowie 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 11602 Silvergate Lane USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give 3 Widowed 4 Divorced Completed Black Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 4 Day Care Provider Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dede Kanu Nwaola Umechuruba N9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Rev. Joshua O. Nathan, Sr. 11602 Silvergate Lane Bowie, MD 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ibgo I and Ground any injury or Igbere, Abia 10-7-2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Dutt Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ysician and le burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes Yes 25. Was case referred to medical Division of Vital Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 \( \text{Yes} 2 Accident
3 Suicide 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated State

DHMH 17 Rev 06-2011

Registrar

AUG 24

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieric U

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8-20-20 T1 6:30amm **Physician** Jones Jack /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Springs Silver Caring Companion Inc. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 19 | 0 Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6 Sex **Funeral** t**X**□M 2□F ATabama 419-12**-**2827 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Silver Spring Md. Montgomery Completed by Funeral Director the 10f. Zip Code 20902 10g. Citizen of What Country? 10e. Street and Number USA permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "" any nitury or other traumer." 1310 Dennis Ave items 23a 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? IINIK 11. Marital Status Timled Forces? UNK

1 XYes 2 No NK

If Yes, Give
Year or Dates: 1 Never Married 2 Married White Specify: 1 Yes 2X No Specify: 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institute of Health College (1-4or 5+) Elementary/Secondary (0-12) Scientist 5+ 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) UNK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1310 Dennis Ave, Silver Spring, Md. Helal Uddin- Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mary I and National 8-23-11 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 411 Kennedy St, N. W. 21. Signature of Funeral Service License Universal Mortuary Inc., Wash, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): sicien a P.O. Box 68760. phys. ası IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? page 1 ☐ Yes 2 ☐XNo 1 Yes 2 No Division of Vital o the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA ို 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Certification; Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature State AUG 24 2011 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 AM Physician/ estadt Month 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NMSd Hagerstown Hage 15town Washington 5. Social Security Number 6. SM 1 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept . 5, 9. Birthplade (State or Foreign **Funeral** Months Days Hours 79 336-24-2945 Illinois **Director** Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Virgimia Berkeley Martinsburg ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 25401 USA 325 Clifford Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Completed 3 X Widowed 4 Divorced Korea White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Manufacturer Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Szajna Ludwik Jestadt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 10132 Williamsport Pike Falling Waters WV 25419 (Daughter) Michelle Gatrell 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XBurial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem. Park Aug. 30,2011 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A.
425 S. Conococheague St. Williamsport, MD 21795 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 12-145/45/5 Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence) **Examiner** Sequentially list conditions, if any, teacing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No 1 Yes 2 Unknown 9 Unknown Part II. **Ot**he**r significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar has autopsy certificate ha lirector, page performe death? 2 No 1 🗌 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of injury Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier of death (Item 23a) (Type, Print) P14014 Murch Pike Hagerstown MD21742 7W-3 oncord 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 28978 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Paul Johnson Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** WM. Regional Medical Center Cumberland Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day Y Months Days Hours 215-16-4147 1 XM 2 🗆 F 89 Maryland Aug. 1922 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD Allegany Barton 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18422 Takoma Drive Funeral 21521 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? WW 1 X Yes 2 No No If Yes, Give Korean Year or Dates. Black, White, etc. þ 1 Never Married 2 Married white 1 ☐ Yes 2 🙀 No Specify. r than "natural", the Medical Exa 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) 12 Ballistics Manufacturer College (1-4 or 5+) Research Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Johnson Laura Warnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18422 Takoma Drive, Barton, Maryland 21521 Department of Health ar Important: If item 27 is any injury or other traunonce. Paul M. Johnson/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cumberland Crematory 08/30/2011 1 Burial 2 X Cremation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onsetland Death Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause E. ter U. cerlyling Cause (Disease or iinjury Due to (or as a consequence of) Examir tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-t use as the attending IF FEMALE 23d. Date of delivery Year Month Day

Physician/ Medical Examiner

with the Maryland

72 hours after death

Baltimore, Maryland 21215-0036

Physician/Medical

signed by tl Completed by page 2 Be ည Certificate: the completed filled in by

law requires that the death certificate be Records, P.O. Box 68760

has

Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h Division of Vital

24 hours a

within 2

To the F

3b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3
Part II. Other significant conditions	s contributing to death but not resulting in	, ,
5. Was case referred to medical		26 Place of Death (Check

1. Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

iniury

M

	23e. Did tobacco us		ribute to the caus					
	24a. Was an autopsy performe(7) 1  Yes 2 No		Were autopsy fin prior to completideath?  1  Yes 2 1	on of cause of				
k only one)								
ome 5 Residence 6 Other (Specify)								
28d. Describe how injury occurred								

l Certifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec
Medical	(Check 2 Medical Examiner	an: To the best of my kno : On the basis of examinat Practioner: To the best of
_	29b. Signature and title of pertifier	n

5 Pending

24 No

1 Yes

27. Manner of Death

1. Natural

work?
1 Yes 2 No nome, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,

4 Nursing Hom

Certifier 1 Certifying Physician: To the best of my knowledge, death		
Check 2 Medical Examiner: On the basis of examination and/or inves		
only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place, and due	to the cause(s) and manner as stated.
signature and title of certifie	29c. License number 0 6 0 3 3 2 8 U	29d. Date signed (Month, Day, Year)

28c. Injury at

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

Dr. Sunil Gupta, 625 Kent Ave, Cumberland, MD 21502

28a. Date of injury (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year Registra Signature AUG 3 U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ wg 23 2011 Year Johnson Sr. Aug 8:50 AM M Leroy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11400 Dundee Dr. Prince Georges Bowie Social Security Numbe **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days 1 X M 2 - F Months Hours 07/30/1936 Director 75 Maryland 214-30-1044 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Directo Maryland Prince Georges
10e. Street and Number 1 XYes 2 No Bowie ò 10f. Zip Code 10g. Citizen of What Country? 23a Funera 11400 Dundee Dr. 20721 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: Black 'natural" 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Research HEM Research Lab Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, of Health and Mental fitem 27 is marked 2 Louis Johnson Lottie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy A Johnson, Jr. (Son) 11400 Dundee Dr. Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) ŏ permit. Page Department of Important: If any injury or once. Chesapeake Crematory | 08/25/2011 | Beltsville, Maryland Name and Address of Facility 21. Signature of Fureral Service Licensee Rendon/Hale Funeral Home sau? Annapolis Rd. Lanham, MD 20706 23a, Part . Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Cerebrovascular Diseas Medical resulting in death) Due to (or as a consequence of Examiner Hypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Disease or linjury that initiated events resulting in death) Last Type 2 Diabetes Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? The law requires that the death Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown P.O. þ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 YUnknown 24b. Were autopsy findings available 24a, Was an has page 2 autopsy performed? Yes 2 No prior to completion of cause of death? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1-1 Natural 5  $\square$  Pending injury Accident
Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the body of the cause(s) and manner stated certifying Nurse Practioner: To the body of the cause (s) and manner at extend (Check nly on 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year, MD D55559 Aug. 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

AUG 2 5 2011

Thomas E. Maslen,

Date filed (Month, Day,

MD 7525 Greenway Center Dr. #312 Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan		artment of H		Mental Hy	gien	е		
			Registrar  1. Decedent's Name (First, Middle, I	ast)		Cer	tificate of D	eatri ————————————————————————————————————	2. Date of De	Reg. N	<u>~201</u>	+	28980
	Physicia Medio		Horace M. Johns	,					Month		ĭ 201	$\begin{bmatrix} 1 \end{bmatrix}$	7:28p M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of								c. County of De		-
											Montgo		y ce (State or Foreign
	Funeral Director		578-36-1640	18 M 2 □ F		82 Yrs.	Months Days	Hours Min.		iy, Year) 5 19	29	DC DC	e (State of Foreign
	nd thow at	្រ	Usual Residence of Decedent  10a. State 10b. County		10c, City	, Town or Lo	cation			-		10d.	. Inside City Limits
	Maryla Ba-f s tified	<b>Funeral Director</b>	MD Prince	Georges	Bow	ie							1 ☒ Yes 2 ☐ No
	nthe has or 2 be no	al Di	10e. Street and Number	<u> </u>			10f. Zip Code			10g. C	itizen of What	Country	?
	ath wit	nner	11503 Chesley Co	ourt  12. Was Decedent 8	Ever in II S	113 V	2072 Vas Decedent of His		necify Yes or No-		ited S1		
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	Never Married 2 ♣ Marrie     Widowed 4 □ Divorced	Armed Forces? d 1 △ Yes 2 ☐ If Yes, Give		l:	f Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)		Black, Wh	nite, etc.	
Maryland 21215-0036	hours natura lical E	Completed	15. Decedent				lent's Usual Occupa			16b.	Kind of Busines		itry
215	nin 72 ne. <b>han "</b> n <b>e Med</b>	dmo	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or 5	ō+)	life. Do	kind of work done do O NOT use retired)	_		,	7 - 3 1	C	ernment
2	Hygier Hygier Int, the	BeC	17. Father's Name (First, Middle, La:	2yrs		Admin	<u>istrative</u>		ant me (First, Middle,			GOV	rernment
au	be file lental I rked o rked o	2	Horace M. Johns	•					Gregor		i Garriarrie)		
ary	should and M is mai		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a				or Town, State,	Zip Coc	de)
χ́.	lealth im 27		Mary T. Johnson	/Wife			Chesley	Court E				_	
Baltimore,	Page 1 a ment of H ant: If ite ury or otl		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		- CE	lace of Dispo emetery, cren ct Line	sition (Name of natory or other place coln	8-2	Date 29-2011	1	Location - City		n, State Maryland
Balt	permit. Page Department of Important: If any injury or once.	, à	21. Sinature Funeral Service Lic	ensee	1		Name and Addres 105 12th						Home
			23a Part 1. Enter the disease, or conshock, or heart failure. List on	omplications that caused y one cause on each line	d the death	n, Do not ente	er the mode of dying	, such as cardia	or respiratory a	rrest,			pproximate Iterval Between
- 1	Physician/	e i	Irrimediate Cause (Final di ease or condition	a Malignan	nt Ne	oplasm	, Larynx					0	nset and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence ofj.							
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events	c								_	
	sate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence ot):							
760	icate l	ledical		d									
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)	у			23d. Date of Month	delivery Da	ay Year
Р. О.	requires that the been signed by the should be detach	by Pr	Part II. Other significant condition	s contributing to death b	out not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute	to the	cause of death?
ds,	quires en sig ould be		Anoxic Brain D	amage					1 🗆	Yes 2	2 □ No 3 □	Probab	oly 4 🏝 Unknown
ၓ	S 00 01	Completed	Anemia						24a. Was auto perf 1 \(\sum \) Yes	psy ormed?	prior t death	o comp	r findings available vletion of cause of
<u>.</u>	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?					ace of Death (Che		2-42			
<b>≒</b>	Physion this containent	2	1 Yes 2 X No 27. Manner of Death	Hospital:  1  Inpati  28a. Date of inju		ER/Outpatier 28b. Time of		4 🖆 Nursing I	Home 5 Resi			ecify)	
0 0	nding tth. : After e funer	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, Da		injury	work	rat ? Yes 2 □ No	28d. Describe	now inju	iry occurred		
INISIC	I or Atter after des Director I in by the	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be	ury - At ho	me, farm, stre	eet, factory, office		28f. Location ( City or To		nd Number or i	Rural Ro	oute Number,
_	To the Hospital or Attending Physician: which 24 hours after death and the Funeral Director. After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of e lurse Practioner: To the	xamination	and/or invest	igation, in my opinio	n. death occurred	at the time, date	and plac	ce, and due to th	ne cause	e(s) and manner stated.
	To the within To the Comp	2	29b. Signature and title of certifier	A CONTRACT TO LITE	Boot of IIIy	in ownedge, c	29c. License				ate signed (Mo		
				y rus			R1699	951			8-23-20	)11	
12	_5		30. Name and address of person who John Hudson-Odc	i 15245 Sha	ady G	rove R	,	ville, M	aryland	208	50		
	Stat Registra		31. Date filed (Month, Day, Year) AUG 2 4 2011	Seneral C	y's Signat	are							

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ William Samuel Sr. Jones ZOII Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SALLEUN HICOMICO ecurity Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 08/29/1923 87 Director 216-16-7167 Marvland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Florida Marathon Monroe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2000 Overseas Highway, Apt. 33G 33050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No 0. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 I Hygiene. 1 ☐ Yes 2 🙀 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates Army 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theodore Griffin Jones Luna Mardela Wright 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Jones/spouse 2000 Overseas Highway, Apt.33G, Marathon, FL33050 20a. Method of Disposition 20b. Place of Disposition (Name of mit. Page 1 a Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhill Memory ☐ Donation 5 ☐ Other (Specify) 8/23/2011 Hebron, MD 售 22 Holloway Funeral Home Professional Association Der Imp 501 Snow Hill Rd., Salisbury, MD 21804 > asp23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Cerebro vaseular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Phumonia Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Exami death certificate be executed inwhire heart + ure Due to (or as consequence of) resulting in death) Last physician Medical 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 No signed by the a 9 Unknown 9 Unknown that the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has pade performed 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 068222 C8-19-11 VP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, MO 21801

DHMH 17 Rev 7/2009

State Registrar

			For State	State of M	Maryland / Dej	oartment of leartificate of		Mental Hy			00000
			Registrar  1. Decedent's Name (First, Middle)	(a last)			Dealli	2. Date of De	Reg. No.2		28982
	Physici		Alfred E. B		т			Month	Day 20	Year 1 1	7:45 A M
-	/Medio Examir		4a. Facility Name (If not institution			4b. City, Town,	or Location of Deat		4c. County		, , , , ,
*	LXaiiii	101	5914 Box Ire			Girdl	letree		Worce	ster	
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs		th		place (State or Foreign
	Director		214-20-0089	1 X M 2 □ F	85 Yrs.	Months Days	Hours Min.	Dec. 5,			yland
	pu.		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or					14	Od Inoido City Limito
	aryla sho	5								'	0d. Inside City Limits 1XXYes 2 □ No
	28a-f	ect	MD Worces 10e. Street and Number	ster	Gird]	etree			10g. Citizen of V	Min at Court	
	with	ä	5914 Box Iron 1	ood.			21829				iti y r
	ns 23	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S. 15			Specify Yes or No	U.S.	e - Americ	an Indian
0	riter iner	교	1 ☐ Never Married 2 ☐ Marri	Armed Forces	s? □No 1949-	B. Was Decedent of If Yes, specify Cub		to Rican, etc.)	Blac	ck, White,	
	al",o	b	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 □Yes 2 No	Specify:		Specify	/: W	hite
ဂ ဂ	72 ho natur fice	Completed		it's Education st grade completed)	16a. Dec	edent's Usual Occu ve kind of work done	pation	rkina	16b. Kind of Bu	usiness/Ind	dustry
7	ithin nan "	nple.	Elementary/Secondary (0-12)	College (1-4o	r 5+)	. DO NOT use retire	ed)	iking		_	_
7	ed wi lygier her th		12		ma	il carrie					service
/alla	be fil ntal F ed otl ever	B	17. Father's Name (First, Middle, Alfred E. B.	•			1	me <i>(First, Middle,</i> W <b>illie</b> S		ne)	
Ž	2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventine runst be notified a	ဥ			405.14-	W Add (Ot	<u> </u>			01-1- 71-	. 0-1-1
200	d 2 sl th an 17 ls r traur		19a. Informant's Name/Relations  Lynn S. Austin		ughter) 710	iling Address (Stree			salisbur		
ש	1 and Health tem 27 other to		20a. Method of Disposition	i (step-dat	20b. Place of Dis	position (Name of	i	Date Date	20c. Location -	, -	
2	Pages nent of int: If ite iry or of		1 <b>½</b> Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		te cemetery, ci	ematory`or other pla	Aug.	21,201	1	•	Maryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event iter must be notified a once.		21. Signature of Funeral Service			Presbyter 22. Name and Addr			SHOW I	1111,	Haryrand
ŏ	permit. Departr Importa any Inju		1 dicien	ell.		22. Name and Addre Short Fu 13 East	ineral Ho: Grove St	me reet De	lmar, D	E 19	940
			23a. Part 1. Enter the isease, or	completions that caus	ed the death. Do not e				_		Approximate
	Physician		shock, or hear failure. List Immediate Cause (Final	only one cause on each	line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	as a consequence of):						UNKNOVYN
E	Examiner			Con	and Aud	disase					
	± ±	ner	Sequentially list conditions, in cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of a	MILL AND ADDRESS OF THE PARTY O					
	ecute ind transi	Examine	that initiated events	c							
, 2	oe execian a		resulting in death) Last	Due to (or a	as a consequence of):						
	icate be executed physician and the burial-transit	dical		d							
	eath certific attending p	Me	IF FEMALE;	220 If you outcom	an of programmy					1.	
2	Attending Prysician: The law requires that the death certificater is death.  scior. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnan	су			te of delive onth	ery Day Year
5	by the datached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown		Other (specify)					
	signed by		Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	tobacco use cont	ribute to th	he cause of death?
2	purres n sigr lld be	d by						1 🗆	Yes 2 □ No	3 Prob	pably 4 🗆 Unknown
3	w requir	Completed						24a, Was	an 24b.	Were auto	psy findings available
ב ב	cate has	mg						auto perfo	psy ormed?	prior to co	mpletion of cause of
ק ק	certificate ector, pag		25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o		1 □ Yes	2 <b>1</b> No
- 3	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	itient 2 ☐ ER/Outpati	ent 3 DOA Oti	her:	Home 5 Resi		er (Specif	f <sub>(</sub> )
) i	oing rnys h. After this funeral di		27. Manner of Death	28a. Date of In	njury 28b. Time	of 28c. Inju			how injury occur	1-7	<i></i>
5 7	ath. or: Af	atic	1 Natural 5 Pendin investig	gation	say, rear)		Yes 2 □ No				
	r Atti	Certification:	3 ☐ Suicide 6 ☐ Could in determine	ined 28e. Place of In building,	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location ( City or To	Street and Numb	er or Rura	al Route Number,
<u></u>	irs affiral or ral Di	Ö	1	0							
200	of the nospital of Attendi within 24 hours after death.  To the Funeral Director; A completely filled in by the to	ical	(Check only 2 Medical	i <b>g Physician:</b> To the bes Examiner: On the basis	of examination and/or	ath occurred at the t investigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as s	stated. o the cause(s)
4	thin 2 the the mpler	Medica	one)	and manner s	stated.			· · · · · · · · · · · · · · · · · · ·			
Ė	\$ <b>4</b> € 5		29b. Signature and title of certifier			29c. Licen			29d. Date signe		
	1910	-	20 Name and Iday	y M.D.			69351		8/17	1291	1
	'VP		30. Name and address of person	who completed cause of	death (Item 23a) (Type	e, Print)	5.0 m 1 21	u Mo	21863		
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	trar's Signature	ر اعتااد	MIGW M	4 170	21000		
	Registra		8/17/AUGII	7 2011 12	wer p.	gar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kreeger Year 2011 ilda PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROCKHILL Hebrew montgomer 4 Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. (Month, Day, Poland Director 103-16-0277 98 Nov. Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6105 Montrose Road 20852 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 K No Specify: Specify 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hebrew School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Menachem Mendel Isenberg Faiga Dymant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Levine/Daughter 911 Mackall Avenue, McLean, Virginia 22101 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Mem. Grds. 08/21/2011 Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitEdward sagel Funeral Direction, maqueenhur mo1597 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Dementi Phylician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner oronary Artery Discase Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated avents aktransit the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Thrive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page performed this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 1 Tes 2 1No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: After 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Descripting Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Mg

3

Timein

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timlin

R172412

8/19/2011.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physician   Vincent William Keyes   4a. Facility Name (find institution, give street and number)   4c. County of Death   4c. Count	de City Limits  ☑ Yes 2 □ No
1. Decedent's Name (First, Middle, Last)   2. Date of Death   3. Tay   1. Model   2. Date of Death   3. Tay	tate or Foreign  de City Limits  Yes 2 \( \subseteq \) No
Washington   Was	tate or Foreign  de City Limits  Yes 2 □ No
Meritus Medical Center   Hagerstown   Washington   S. social Security Number   S. so	de City Limits  ☑ Yes 2 □ No
Social Security Number   Social Security Num	de City Limits  ☑ Yes 2 □ No
Director    Director	de City Limits  ☑ Yes 2 □ No
10a. State   10b. County   10c. City, Town or Location   10d. Inside the part of the par	₹Yes 2 □ No
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	an,
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	uring
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	uring
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	uring
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	te
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
hysician/ Medical =xaminer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Dut to (or ast consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
The cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Dise	al Between and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
G ± € g Unknown   9 Unknown	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	
1   Yes 2   No 3   Probably  24a. Was an autopsy performed? 1   Yes 2   No 1   Yes 2	n of cause of
25. Was case referred to medical examiner?  1	
27. Manner of Death 28a. Date of injury (Month, Day, Year) 27b. Tall Vatural 5 Pending 28c. Injury at work? 28d. Describe how injury occurred injury 28d. Describe how injury occurred	
28a. Date of injury work?  Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year)  28b. Time of injury M 1 Yes 2 No  28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Injury - At home, farm, street, factory, office building, etc. (Specify)	lumber,
City or flown, State)  29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	d manner stated.
only one) 3 Description Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and time of certifier  29c. License number  29d. Date signed (Month, Day, Yea	011
N-12 MONIQUE Coma M) 11116 Medical Caropus Rd. Hage Stown &	W 2174
State Registrar  31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup>20 Rose Vaeth Kapral August 2011 2:00 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth
(Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2XXF Months Country) Maryland N/A**Director** August Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Annapolis Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country?
U.S.A. Funeral 21401 911 Poplar Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. by 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Ń/A Be 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Courtney Vaeth 17. Father's Name (First, Middle, Last) Mark David Kapral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Mark Kapral/father 911 Poplar Avenue Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 8/23/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of duing, such as cardiac or respiratory arrest, Approximate Interval Between On et and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, i i n disease or condition resulting in death) min Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Dav Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မူ 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d, Date signed (Month, Dav. Year) PP6875 011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Jessica Russell, MD

AUG 2 3 2011

31. Date filed (Month, Day, Year)

Annapolis, Maryland

2001 Medical Parkway

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Emma Vaeth Kapral 28 2011 2:15 Рм August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Anne Arundel Examiner 4b. City, Town, or Location of Death Annapolis Anne Arundel Medical Center 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months N/A Days Hours 1 M 2XXF Maryland **Director** Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Annapolis Maryland Anne Arundel 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 911 Poplar Avenue Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) N/A N/A N/A Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Mark David Kapral Elizabeth Courtney Vaeth 19a. Informant's Name/Relationship (Type, Print)
Mark Kapral/father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Poplar Avenue Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 8/23/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Baltimore Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 min disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 2 No 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

2001 Medical Parkway

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jessica Russell, MD

AUG 23 2011

31. Date filed (Month, Day, Year)

D\$ \$68757

Annapolis, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 28987 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 26, 2011 12:15PM Donald Kisner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>702</u> Morris Ave. Apt#102 Friendsville Garrett 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Wonths Days Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Days 1 1 7 7 2 2 7 West Virginia 1936 Director 233-56-7702 74 Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Friendsville MD Garrett 1 X Yes 2 No 0 10e, Street and Number 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 702 Morris Ave. Apt#102 21531 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mable Hawkins Robert Ray Kisner Edwinna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Morris/Daughter 88 Hoyes Run RD., Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crem. 8/29/2011 Davidsville, PA 22. Name and Address of Facility Newman Funeral Homes P.A. Kic 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that conted shock, or heart failure. List only one cause on each limit. h. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition e 245 resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Dae to for as a consequence of, and Il-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natura 5 Pending after death.

Director: Af
in by the fur 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2  $\square$  No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific Day, Year

State

Box 68760

P.O.

**Division of Vital** 

311 N. Fourth St., Oakland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

Thomas Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28988 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Whitter Keefer September 2011 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Northampton Manor Frederick Frederick . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 92 Months Hours 213-18-6130 1 X M 2 □ F **Director** Mary Land 1919 June 11, Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 U.S.A. 913 Cherokee Trail death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Electrical Engineer Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles S. Keefer Jessie Alice Whitter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 913 Cherokee Trail, Frederick, MD 21701 Mrs. Helen L. Keefer, wife 20a. Method of Disposition
1 Description 
3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Olivet Cemetery Sept. 7, 2011 Frederick, MD 4 Donation 5 Other (Specify) 21. Sign Ture of Tuperal Service Licensee 22. Neeneyddand Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or composhock, or heart failure. List only on eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Ste that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🔀 1 Yes 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

8

Volk

elly wolle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

100502

St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimor yrs. last birthday Tacomo ark Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 - F Months Min. Hours 8 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 □ No 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 2 SA 00 hardson 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No and Mental Hygiene. is marked other than "natural", Specify: 3 Widowed 4 Divorced Completed lack Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Annapolis any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sincla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 ichardsoncer. Poroth. doc mo Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State Denation 5 Other (Specify) 08-20-2011 madison Ceni permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funchel Street, Cambridge Roce 23a. Part 1. Ent 🕮 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Dre to (or Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the the To the Hospital or Attending Physician: The law requires that the c within 24 hours after death.

To the Funeral Director: After this certificate has been signed by th signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 2 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 125 address of person who completed cause of death (Item 23a) Type, Print 31. Date filed (Month, Day, Year AUG 18 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ammend 20b 08/24/11 State of Maryland / Department of Health and Mental Hygiene KW/CCHD 28990 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20 2011 8:25 PM M Bernard Leon Lankford Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Calvert Prince Frederick Burnett-Calvert Hospice House Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-22-0896 1 X M 2 - F 10/14/1927 Maf v Tánd Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Prince Frederick Maryland Calvert 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? 4855 Sandy Point Road United States 20678 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 X Married Yes, Give 2 🗆 N Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 V No Specify: 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Amy Langley Frederick Lankford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine H. Lankford - wife 4855 Sandy Point Rd. Prince Frederick MD 20678 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Asbury Cemetery 08/24/2011 08/24/2011 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Barstow Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 K aus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
MONTHS Immediate Cause (Final SQUAMOUS CELL CARCINOMA Physician METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to manufacture cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? H005100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

KIN

Date filed (Month, Day, Year) State Registrar

40370

## 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sep 1 Physician/ . <u>2011</u> Marie Lueck Agnes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany 1004 Oldtown Road Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months Days Hours Min. Aug 5, Director 214-16-2747 90 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director Cumberland MD Allegany 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21502 1004 Oldtown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. Physical Analysis Lab. lab technician 2 should be filed w h and Mental Hygi 7 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances Laing William A. Schaffer t. Page 1 and 2 should be thent of Health and Mertant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1004 Oldtown Road Cumberland Patricia Ruppenkamp 1004 Oldtown Road daughte other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) St. Mary's Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/3/2011 4 Donation 5 Other (Specify) Cumberland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ❤ No 9 ☐ Unknown sate has been signed by the atte page 2 should be detached for it P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yeş 2 ☐ No 3 ☐ Probably 4 No Unknown 24a. Was an autopsy performed this certificate Yes 2 C To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. RD. CLYMPERLAND MI

1 Yes

Month

Dav

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Year

5:15 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

MD 21502

Onset and Death

MD

1 XYes 2 No

Country) MD

white

USA

Black, White, etc.

State Registrar

Medical

29a. Certifier

31. Date filed (Month)

29b. Signature and title of certifier

925 BISHOW

D2690

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. N2011 28992
of Death th Day Year
3115 <sup>†</sup> 13 2011 2114 M
Talbot
of Birth oth, Day, Year) 17–1929 9. Birthplace (State or Foreign Country) CALIFORNIA
10d. Inside City Limits
1 ☐ Yes 2 <b>X</b> No
10g. Citizen of What Country?
or No- 14. Race - American Indian,
Black, White, etc.
Specify: WHITE  16b. Kind of Business Industry
MOVIE  Middle, Maiden Surname)
VHITTEMORE
Number, City or Town, State, Zip Code)
ASTON, MD 21601  20c. Location - City or Town, State
STEVENSVILLE, MD
IEWNAM FUNERAL HOME, P.A.
tory arrest,  Approximate Interval Between
Onset and Death
5 years
23d. Date of delivery  Month Day Year
e. Did tobacco use contribute to the cause of death?  1  Yes 2  O 3 Probably 4 Unknown
a. Was an 24b. Were autopsy findings available prior to completion of cause of
autopsy performed? death?  Les 2 No 1 Yes 2 No
ne)
☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
cation (Street and Number or Rural Route Number, v or Town, State)
o the cause(s) and manner as stated. e, date and place, and due to the cause(s) and manner stated. Jue to the cause(s) and manner as stated.
29d. Date signed (Month, Day, Year)
08-15-2011
21601

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28993 State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BYRON E. LANGLEY August Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rehabilitation +/Vursing Wicomico isburi If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 X M 2 - F Months Days Hours Day, 461-24-9759 ELECTRA Director 1926 MAY Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director MD. Wicomico EDEN 1 🗌 Yes 2 🕱 No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 25077 COLLINS WHARF ROAD 21822 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify: Completed WHITE Year or Dates. US NAVY 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 WALLOPS MACHINEST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any niury or other traumatic ev ono ည CLADE WILSON LANGLEY ILONA STE WART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTE PRICE LANGLEY (SPOUSE) 25077 COLLINS WHARF RD. EDEN MD. 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-16-2011 PARKSLEY, VA. SHORE CREMATORY Signature of Funeral Service Licenses 22. Name and Address of Facility HCLLOWAY FUNERAL HOME, PA avid At. 501 SNOW HILL RD. SALISBURY MD. CFSP 23a, Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ear Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ō Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records. Completed 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INP #. 200 illiam m.D

Registrar

State

31. Date filed (Month, Day, Year)

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 28994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hugust Physician/ Roy Aldine MAGAHA 5:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Oct. 28, 1934 Maryland 76 Yrs 217-28-5417 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral 21740 U.S.A. 1007 Queen Amne's Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ 1953 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced 1957 Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry ulth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) correctional officer government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ James Roy Magaha Orpha Zellers permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Langley Drive, Hagerstown, Maryland 21740 Stephen Magaha - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Aug. 2011 Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home Volut BOG 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final by intary GASTRO INTESTINAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner COACULOX Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last CHRONIC To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical TOURTONS,ON MONAR Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the a detached f Unknown P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

MEDICAL CAMPUS RD

747A160-WILSON

32. Register's Signature

HAGIGATIONIN MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 August August Physician/ McCardell Maxine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Meritus Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number 7 Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 29,1927 Maryland october 83 219-20-4239 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State at Director Examiner must be notified 1 X Yes 2 □ No Williamsport Maryland Washington 10g. Citizen of What Country? 5 10e Street and Number 10f Zip Code items 23a Funeral USA 21795 21 South Conococheague St. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married "natural", or 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced the Medical Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Dietician Ŕ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luewillie Thomas Braxton Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 23 S. Conococheague St. Williamsport, Maryland 21795 Debra Cline (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cedar Lawn Mem. Park Aug. 20,201 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A of Funeral Security 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CVETE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (dr as a consequence of). of any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last ng physician ar as the burial-t Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year for Month Pregnant at time of death 1 Yes 2 No detached Unknown P.O. has been signed by the 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Hyper Con 210n 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNo Other: 1 Inpatient 2 R/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 1 Natural work? 5 Pending 2 🗌 No 2 ☐ Accident 3 ☐ Suicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signaty 29d. Date signed (Month, Day, Year, MU leted cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar

TIL) - 4

80

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wilbur Renfrew McElroy August 2<sup>2</sup>4<sup>9</sup> 2011 8:00 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Williamsport Nursing Home Williamsport 8. Date of Birth Day, 24 If Under 1 Year If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days Hours (Month, Day, August 1 XM 2 □ F 219-07-9887 1914 Pennsylvania 97 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Boonsboro 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8428 Old National Pike 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Chemist Doctor of Chemistry Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Wilbur McElroy Beulah Renfrew McElroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8428 Old National Pike Boonsboro, MD 21713 Margaret O. McElroy-wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 8-29-2011 Chambersburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed's death? To the Hospital or Attending Physician: INF-within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa**y**ure 29d. Date signed (Month, Day, Year) MI address of person who completed cause of death (Item 23a) (Type, Print) JW-25 580C Hagerstown MD 21742 Mahmood Northerr State 36 Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 28997 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1446 м Beverly Ann Medical Murray 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/10/1951 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 K Hours Min. Director 220-54-2531 60 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 15135 Bloyers Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates. White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7; nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Bank Teller</u> Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) L. Cosgrove Mary Leasure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Murray / Spouse Α. 5135 Bloyers Ave., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or c 1🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 8/24/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nyocardia disease or condition resulting in death) Medical Due to br as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached if 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Certificate: To Be Completed 1 Tes 2 No 3 Probably 4 Unknown labetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 X No 1 🔲 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ★ER/Dutpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) ARCU 064221 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 MEDICAL CAMPUS RD #223 HAGGRSTOWN, MD SHERIF 31. Date filed (Montl State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28998 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 2011 George Jewell Mohn 7:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood Retirement Center Williamsport Washington Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 19,1921 Birthplace (State or Foreign Country) Months Days Hours 347-14-8828 89 Illinois Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🔀 No Maryland| Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Affiled Forces: 1 Tyes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mathematician Computer Manuf. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gjermund James Mohn Leita Lucille Mansfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig G. Mohn - Son 8953 Light Street Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial 2 Cremation Other (Sp Hagerstown Crematory 08-24-2011 | Hagerstown, Maryland ure of Fuz ral Servi 22. Name and Address of FacilityOsborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused is shock, or heart failure. List only one cause on each line sease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events."

/Medical

10a. State

Director

Funeral

þ

Completed

Be

ပ

21. Signa

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner attending physician and for use as the burial-trar After this certificate has been signed by the funeral director, page 2 should be detached Certification: To s after decreal Director After the fire

29b. Signa

Medical JW-15+1 State Registrar

	Due to (or as a consequence of):				
Sequentially list conditions, and leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b				
	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year			
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown			
15 CATON		24a. Was an autopsy performed?  1 □ Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No			
25. Was case referred to medical examiner?	26. Place	of Death (Check only one)			
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4 Nu	rsing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work?  □ M 28c. Injury at Work?  □ 1 □ Yes 2 □ N	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date animiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	d place, and due to the cause(s) and manner as stated. th occurred at the time, date and place, and due to the cause(s)			

nse number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Cletus MYERS August 24,  $201^{\text{Year}}$ 3:34 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16505 Virginia Ave., Cottage 223 Washington Williamsport Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 25, 1924 If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1X M 2 | F Hours Maryland **Director** 220-18-3061 87 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Williamsport 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Ave., Cottage 223 21795 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 1943-45 Specify. white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator photographic studio Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental I ပ William L. Myers Vera unknown and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,\,21795$ Health item 27 16505 Virginia Ave., Cottage 223, Williamsport, Md. Lillian Myers - wife other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, Maryland 21. Signature Ameral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician ongestive disease or condition 1998 Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediat cause. Enter Underlying reactionies of Cause (Disease or injury that initiated events burial-transi and resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death Yes 2 No signed by the a ld be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an the Hospital or Attending Physician: The law thin 24 hours after death. the Funeral Director: After this certificate has I mpleted filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ည ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners To the best of my ic calledge within 2 occurred at the time, data and place, and due to the 29b. Signature and title of certifie 29c. License number D14800 masturo

State Registrar Hagerstown MO 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

MASSOUD B. ALIZADEH, HO. 240 Prederick St.

32. Regis ar's Signature

Please Type or Print in Black, Indelible Ink I Ensure Alb Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Leanna Moore Myust Medical Facility Name (if not Institution, xaminer give street and number) 4c County of Death 4b. City, Town, or Location of Death 5 HUEDUE lemple nnce **Funeral** If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months (Month, 824, Year) La Country Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits notified 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? 20 . Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic event, the Medical Examiner 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 
Widowed 4 Divorced Specify: Bac Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ucation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ scar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moore-West Grace 20b. Place of Disposition (Name of 20R 1 Chino fitt or TWA ö Southside Grenation Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Lifense dith 9 Richmond, Int 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. 23a Part 1. Enter the disease. Approximate Interval Between Immediate Cause (Final Physician/ curdioThrombotic Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiovascular distance atheroscherotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 1 ☐ Yes ∠ w 9 ☐ Unknown detached Jate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy After this certificate performed? Yes 2 **Director:** After this certific in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RajupakseniD 5 2835 Smith 9 State

Registrar